NOTE

This Microfiche meets the quality requirements of the American National Standard for Microfiche of Documents (ANSI PH5.9-1975). However, because of imperfections in the document from which it was made, it contains images that are illegible or difficult to read. The source document for this microfiche is the best copy that could be obtained prior to filming.

CIS Congressional Information Service, Inc.
Washington, D.C.

INTRAVENOUS DRUG USE AND AIDS: THE IMPACT ON THE BLACK COMMUNITY

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

SEPTEMBER 25, 1987

Printed for the use of the
Select Committee on Narcotics Abuse and Control

SCNAC-100-1-15

U.S. GOVERNMENT PRINTING OFFICE

82-887 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H961-31

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

(100th Congress)

CHARLES B. RANGEL, New York, *Chairman*

PETER W. RODINO, JR., New Jersey
FORTNEY H. (PETE) STARK, California
JAMES H. SCHEUER, New York
CARDISS COLLINS, Illinois
DANIEL K. AKAKA, Hawaii
FRANK J. GUARINI, New Jersey
DANTE B. FASCELL, Florida
WALTER E. FAUNTROY, District of Columbia
WILLIAM J. HUGHES, New Jersey
MEL LEVINE, California
SOLOMON P. ORTIZ, Texas
LAWRENCE J. SMITH, Florida
EDOLPHUS "ED" TOWNS, New York
JAMES A. TRAFICANT, JR., Ohio

BENJAMIN A. GILMAN, New York
LAWRENCE COUGHLIN, Pennsylvania
E. CLAY SHAW, JR., Florida
MICHAEL G. OXLEY, Ohio
STAN PARRIS, Virginia
DUNCAN HUNTER, California
JOSEPH J. DIOGUARDI, New York
F. JAMES SENSENBRENNER, JR., Wisconsin
ROBERT K. DORNAN, California
TOM LEWIS, Florida

COMMITTEE STAFF

EDWARD H. JURITH, *Staff Director*
ELLIOTT A. BROWN, *Minority Staff Director*

CONTENTS

	Page
Opening statement of Chairman Charles B. Rangel	1
Testimony of Dr. Charles Schuster, Director, National Institute on Drug Abuse	4
Testimony of Dr. Gary Noble, Public Health Service Aids Coordinator, Centers for Disease Control	8
Testimony of Dr. Burton Lee, Presidents Commission on the H.I.V. Epidemic, and Physician at Memorial Sloan Kettering Cancer Center	11
Testimony of Margaret Heagarty, M.D	14
Testimony of J. Michael Quinlan, Director, Federal Bureau of Prisons	18
Testimony of George Hansen, Former Member of the House of Representatives	20
Testimony of Anthony Travisono, Executive Director, American Correctional Association	32
Testimony of Dr. Lorraine Hale, Executive Director, Hale House	36
Testimony of Dr. Lawrence Brown	41
Prepared statements:	
Chairman Charles B. Rangel	59
Dr. Charles R. Schuster	64
Dr. Gray R. Noble	66
Dr. Burton J. Lee III	71
Dr. Margaret C. Heagarty	75
J. Michael Quinlan	81
Anthony P. Travisono	90
Dr. Lawrence S. Brown, Jr	103
Congressman George Hansen	110
Submissions for the record: J. Michael Quinlan	113

INTRAVENOUS DRUG USE AND AIDS: THE IMPACT ON THE BLACK COMMUNITY

FRIDAY, SEPTEMBER 25, 1987

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, DC.

The select committee met, pursuant to call, at 9 a.m., in room 1100, Longworth House Office Building. Hon. Charles B. Rangel (chairman of the select committee) presiding.

Present: Representatives Charles B. Rangel and William J. Hughes.

Staff present: Edward H. Jurith, staff director; Elliott A. Brown, minority staff director; Barbara A. Stolz, professional staff; James W. Lawrence, minority professional staff; Michael J. Kelley, staff counsel; James Alexander, professional staff; Bob Weiner, press secretary; and Heide Haberlandt, staff assistant.

Mr. RANGEL. The hearings of the Select Committee on Narcotics Abuse and Control will now come to order.

I want to extend a special welcome to our guests, many of whom are here to participate in the Congressional Black Caucus weekend, and also to the wide range of witnesses that will be here to discuss the impact of AIDS as it relates to the intravenous drug abuse upon the black community.

Most people believe that one of the most serious health problems our country is facing today is the AIDS problem. There are already 40,000 reported AIDS cases, with thousands more infected with the AIDS virus.

Among the victims of AIDS, the black community seems to be overrepresented, and so what could be considered a health problem for our Nation could indeed be a survival problem for the black community. Our children and our women and our men find themselves with the disease disproportionately as compared to other communities.

It is generally believed that through the common sharing of needles, syringes, swabs and other drug-related instruments that are contaminated with the AIDS-infected blood, the virus is being rapidly transmitted through drug users and AIDS victims. Among the black males with AIDS, IV drug use, which is basically the injection of heroin, seems to account for more than 40 percent of the reported cases. There is the IV connection among women with AIDS; 50 percent of them are IV drug users, and the second largest group of women vulnerable to AIDS are the sexual partners of IV drug users. Most of these women are black or Hispanic, as in the

case of IV drug users. In most pediatric cases 88 to 90 percent of the children being born with the AIDS virus are reported to be black or Hispanic. So, we are here today not only to point out the serious nature of this problem, but to try to get some answers as to what we can do about it.

In our prison system, we find that 75 percent of those with AIDS entering Federal prisons are IV drug abusers and they return to the community with this disease.

In the black community, we have found through recent studies that while the government's attempt and the community's attempt to educate the drug users has been successful with many of the middle-income communities, that in the poorer communities where we find less jobs, less homes and less hope that the attempts to educate and prevent drug use has not been that successful.

As a matter of fact, the—there has been an increase in the use of heroin notwithstanding the fact that in the general and international drug abuse population, there has been an increase in cocaine abuse and decrease in heroin abuse. Taking a look at the prison population we see the disproportionate number of blacks in that system, and recognize that more often than not, we find a situation where these people leave prison going to the general community.

And so in Harlem Hospital we find many children that are abandoned without love, with the virus. We have some people in the community that are reaching out to remind us of our moral responsibility, which we hope we will see the church more involved in, but without legal responsibility in the Congress as well.

And so, for that reason, I am pleased that we have serving on the panel and as witnesses Dr. Charles Schuster, who is the Director of the National Institute on Drug Abuse. And he will be sharing with us, he will kick off our hearing this morning—exactly what responsibilities the Federal Government has assumed.

Dr. Gary Noble is here with us. He is the AIDS Coordinator for the Public Health Service, and he is on the staff of the Centers for Disease Control in Atlanta. We also are pleased to have from New York a physician from Memorial Sloan Kettering Cancer Center in New York, Dr. Burton Lee. Dr. Lee is a member of the President's Commission on the AIDS Epidemic. They have the awesome responsibility to evaluate the depth and the nature of the problem and report to the President of the United States.

Recently, I had the pleasure of meeting with him at Mother Hale's House with Dr. Lorraine Hale, and the sensitivity of the Commission in terms of the special problems that children, especially in the black community, were having convinces me that notwithstanding the budget crisis, that our Nation must respond with some assistance in that area.

Dr. Margaret Heagarty, who is the Chief of Pediatrics in Harlem Hospital, has to be the first person that brought this to my attention. She is a hard-working leader and a sensitive person as relates to the care of children, and she takes no nonsense from anyone in protecting those poor and powerless children that are in her keep at Harlem Hospital. She has been willing to share her expertise with other communities so that they can possibly avoid the tragedies that we go through on a daily basis at our own Harlem Hospital. Because she has been willing to share herself with other com-

mittees that are holding hearings at the same time, we may have to make some special considerations for her as it relates to her testifying.

Also, we will have with us Director of the Federal Bureau of Prisons, J. Michael Quinlan, who will tell us what is going on in the Federal system. While we don't have jurisdiction over the State system, we may be asking him in very general terms what we can do to protect prisoners as well as the general population from the spread of this deadly disease.

A former colleague and member of the House of Representatives, George Hansen is in the audience—right here. Because he has lost so much weight, I didn't recognize him at first, but it takes a bit of courage for someone that has attained the status that you have been willing not just to feel sorry for yourself, but to be willing to come to this hearing, to Capitol Hill, to share the experiences you have, and more importantly than that, to try to advise us what we can do to prevent this from happening.

I will be honest, that because you are who you are, this committee made a special effort to ask you to come. Because there are so many hopeless and powerless people that are in our prisons that voices are not heard and that the tragedy that beset you in your political and personal life. I hope that perhaps through this hearing we can make a contribution, which I know that you would want to do, to prevent some of the things which I read that you were concerned about. I thank you for being here.

Anthony Travisano is the Executive Director of the American Correctional Association. He will be here shortly, and he will tell us in more general terms the problems we are facing in our prisons.

I have talked briefly about Mother Hale, because she has now received national attention, and it is somewhat awkward for someone who has the charm and has seen the work that she has done for the people in my community without fearing, without clamor, without visits, without recognition by the President of the United States or the President of the City Council for that matter, but she and her daughter, Dr. Lorraine Hale, have been in the forefront of providing health care for children. But more importantly than that, Lorraine, when people refuse to look at those children in our hospital as their own, because of fear and ignorance that they may contaminate their own natural children or foster care children, I think one of the most important things you provide is that they know that you and your mother could not possibly love your children more than they love theirs. When you receive these children into your home and into your hearts, it sends a lesson to all of us that we have to do more. And so, you and your mother are symbols not only for our Harlem community, but indeed for the Nation as to what can and should be done.

And we will be hearing from Dr. Lawrence Brown, and I will announce his presence when he arrives.

Dr. Schuster and I have worked together in Washington, and he participated in the Vienna International Drug Conference recently. He is a dedicated public servant that could be doing a lot of other things, but probably not receive the psychic income that he does in trying to make life better for Americans. We are pleased that on

this Friday, he has taken time out to share with us his views on this very serious and most important international and national problem. Thank you, Doctor.

[Mr. Rangel's opening statement appears on p. 59.]

TESTIMONY OF DR. CHARLES SCHUSTER, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

Dr. SCHUSTER. Thank you very much, Mr. Rangel.

Mr. Chairman and members of the committee, and members of the Congressional Black Caucus, my name is Charles Schuster, and I am the Director of the National Institute on Drug Abuse, better known as NIDA, of the Alcohol, Drug Abuse, and Mental Health Administration. We are grateful for this opportunity to participate in this hearing on the impact of drug abuse and Acquired Immume Deficiency Syndrome on minority communities.

Many black communities in this country face two major epidemics today, drug abuse and AIDS, and as Mr. Rangel said, there is a close connection between these two diseases.

We at NIDA are well aware that black inner city communities are disproportionately affected by these tragic problems and we are mounting special initiatives to reduce the incidence of drug abuse and control the spread of AIDS in these communities.

Our efforts are devoted to reducing the spread of AIDS among IV drug abusers, their sexual partners and their children. Now, before I describe some of these initiatives, let me give you some idea of the dimension of the problem.

Epidemiologists have conservatively estimated that there are approximately 1.2 million intravenous drug abusers in the country at this time, and about 54 percent are black. It is not surprising then to find that blacks are overrepresented among those who have gotten AIDS since intravenous drug use—specifically the sharing of needles or works with contaminated blood—is one of the primary ways that the AIDS virus is spread.

Data collected and compiled by the Centers for Disease Control indicate that IV drug abusers make up one-quarter of all AIDS cases. The statistics show that 65 percent of all IV drug abusers with AIDS are black or Hispanic.

But the CDC AIDS data are only part of the story, the tip of the iceberg. It has been estimated that approximately 250,000 to 300,000 intravenous drug abusers may already be infected with the AIDS virus. Seroprevalance studies of drug abuse clients in treatment indicate that more than 50 percent of all the clients in New York City and northern New Jersey are already infected with the virus.

Yet, only one of six heroin addicts is in treatment at any one time. At this time, we know relatively little about the rates of infection among IV drug abusers who are not in treatment. We have no idea as to how many sexual partners or children of IV drug users may be infected.

We do know that IV drug abusers are transmitting the virus through sexual contact to their sexual partners and that their sexual partners are transmitting it to their children.

Now, there are major problems with attempting to work with this population. In general, IV drug abusers are difficult to reach. They tend to be heroin addicts, poorly educated, living in the inner city part of large urban areas, and fall into the lower city socioeconomic strata.

They also have high rates of psychopathology and criminality and often have unattended medical problems. In addition, because of their involvement with illicit substance abuse as well as other criminal activities, they tend to be distrustful of authority and seek personal anonymity.

As a result, even the identification of heroin addicts is a difficult problem. Presenting educational material to them in a manner that is understood and trusted is doubly difficult.

A further challenge lies in the fact that many non-IV drug using people are also at high risk if they are unaware that their sexual partners are drug addicts. This is often the case, particularly in Hispanic communities, where the idea of being a drug user is hidden from one's sexual partner. Further, the sexual partner becomes infected and then they may pass on the virus to other sexual partners without suspecting that they are doing so; and for women, they could also pass on the infection to their children.

Now, even when high-risk individuals can be contacted, it is important to recognize that it is extremely difficult to change health and sexual behaviors. Researchers in the area of health behavior change have learned that one's ability to utilize health education information and to make changes in one's behavior largely depends on socioeconomic status, educational level, sense of power and control, and one's vocation.

Unfortunately, IV drug abusers and their sexual partners are the—of the inverse of these characteristics. This, the IV drug abusers and their sexual partners are extremely resistant to attempts to change their behavior through health education information.

Now, what the message that we need to get across to them? For both male and female drug addicts, the first and foremost message must be, stop using drugs, particularly stop using drugs intravenously, but for those who cannot or will not stop, we have to prevent the spread of AIDS through behavioral changes in two ways.

First, they have to stop sharing needles; and secondly, they have to learn how to properly sterilize them. Finally, if they have already acquired the virus, they have to learn to engage in safer sexual practices so this disease is not transmitted to their sexual partner.

Now, if we are going to bring about sustained behavior change in this type of person, we must find and gain their trust and provide culturally sensitive education and prevention programs. For those who are addicted to drugs, we must continue to expand the availability of drug abuse outreach and treatment services. We must continue to support research that will improve our efforts to treat and prevent IV drug abuse.

Now, let me cite a few examples of the kinds of activities in interventions that the National Institute on Drug Abuse is currently undertaking in order to prevent the spread of AIDS amongst IV drug abusers and their sexual partners and their children.

All of these activities are of course, relevant to the health and welfare of all Americans, regardless of color or ethnicity, but the Institute is particularly committed to focusing projects and resources on the special needs of the minority community.

First, let me talk about our educational programs. NIDA has designed and implemented a series of AIDS training programs for the staff of the State drug abuse authorities, drug treatment programs and agencies that serve or come into contact with IV drug abusers, their sexual partners and/or prostitutes. We highlight prostitutes because, first, many of them are also IV drug abusers, but secondly, they are also frequently the sexual partners of IV drug abusers.

So far, we have provided training to 2700 drug abuse counselors and administrators in 23 States, and further, we have a training of trainers programs in which 90 individuals have been trained, so that they can deliver NIDA's AIDS training program themselves.

More than half of these trainers are black. NIDA is also placing special emphasis on reaching and effectively communicating information about AIDS to minority groups. For example, we recently have had. in coordination with the Congress of the National Black Churches, a meeting entitled, "AIDS Crisis in Black America Leadership."

More than 30 church leaders participated to become educated on the extent of drug abuse and AIDS in the black community, the relationship between AIDS and drug abuse, and NIDA's AIDS initiatives which they could take advantage of.

Further, we talked with them about the fact that many communities are reluctant to allow new treatment facilities to be implemented in their area, and we thought that these community leaders may have a very positive impact in helping the communities to recognize that they already have IV drug abusers there, and that if they allow treatment units to be placed there, criminal behavior and IV drug-using behavior are going to be decreased.

NIDA is also concerned with the many policy issues that surround the problems of AIDS and IV drug abuse, and we are holding technical review meetings in which scholars, scientists, researchers, et cetera are called in to give us the best advice possible.

Issues such as should we institute drug abuse treatment for IV drug abuse, should we start needle exchange programs? These are issues that have to be publicly debated and acted upon by both State and Federal authorities.

NIDA also has a drug abuse information and referral hotline. I will give you the number. It is 1-800-662-HELP. Over the past year, we have been dealing with the problem of referring people for treatment. We have had over 30,000 calls since this hotline was initiated. This year, in the fall, we are going to add an additional dimension, that is information about the AIDS virus and about its relationship to IV drug abuse.

Finally, I would like to mention that we are launching a nationwide, $10 million community-based AIDS outreach prevention project, which is targeted to IV drug abusers, their sexual partners and prostitutes in inner city communities.

Through this demonstration grant program, many thousands of individuals at high risk for AIDS will be reached quickly and educated regarding the risks associated with AIDS and on how to

change behavior that places them at risk. As part of this effort, comprehensive outreach programs are being established in New York, Philadelphia, Miami, Chicago and San Francisco.

In addition, more specialized outreach programs are being initiated in 15 other cities. All of these outreach efforts are being coordinated at the national level so that the participating agencies and organizations will be in a position to gauge their effectiveness of different outreach approaches.

In addition to this coordination of participating groups, there will be coordination among all levels of government, and this will include collaboration with the Centers for Disease Control and State and local health departments.

Finally, I would like to mention that we are, in addition to these large-scale community demonstration grants, we have over 66 research grants dealing with the problem of IV drug abuse and AIDS. To end up, I would like to say that we are attempting through research as well as through service to get at the population of IV drug abusers, their sexual partners and their children.

We recognize the fact that time is of the essence, the AIDS virus spreads very rapidly through the intravenous drug using populations. In New York City, for example, in 1978, stored blood samples have been analyzed from that period and virtually zero of them were positive for the AIDS virus. Stored blood samples from 1980 showed about 40 percent—and thus, in two years, the AIDS virus spread from virtually zero to about 40 percent of the IV drug-using population.

Therefore, we feel very strongly we do not have the time to wait. We must implement prevention programs, and as well, we must increase the treatment capacity of our treatment services so that when we get people interested in the treatment, we will be able to absorb them.

I will stop now. Thank you.

[The statement of Dr. Schuster appears on p. 64.]

Mr. RANGEL. Thank you, Dr. Schuster.

The Chair welcomes Congressman Bill Hughes, who is the subcommittee chairman of Crime of the Judiciary Committee, which has legislative jurisdiction over this subject. I really want to thank you for making a special effort to be with us today.

Dr. Schuster, at some point, because we want to hear from all of our witnesses, I would like to hear from you as to whether or not you are sharing the information that you have given us today with Members of Congress.

Unfortunately, members of the Congressional Black Caucus have more than our share of the people that have been affected by this disease, and while I am pleased to see that you have an outreach program, I think it would be more effective if the community and the political leadership of these communities knew with whom you are working and with whom the contracts are, so that we could all be working on this together.

And also, at some later point, throughout your testimony you talked about the powerlessness, the helplessness of some of the people who are dependent on drugs, who therefore find themselves affected with the disease and perhaps you might share your views with me as to whether or not you believe there is a Federal or na-

tional responsibility to deal with some of these underlying problems.

We now welcome the testimony of Dr. Gary Noble, who comes to us from the Centers for Disease Control and is the Public Health Service AIDS Coordinator. Thank you for being with us.

TESTIMONY OF DR. GARY NOBLE, M.D., PUBLIC HEALTH SERVICE AIDS COORDINATOR, CENTERS FOR DISEASE CONTROL

Dr. NOBLE. Thank you, Congressman Rangel and members of the committee.

I am Dr. Gary Noble, the Public Health Service AIDS Coordinator, working in the Office of the Assistant Secretary of Health in Washington. Thank you for the opportunity to participate in this discussion.

AIDS is a unique disease in the history of mankind. Like hepatitis B virus, it can be transmitted by sexual intercourse and through sharing of IV drug needles and syringes and by mothers to their unborn or newly born babies.

But like herpes virus, it causes a latent, lifelong infection, however the disease is highly fatal, more like a cancer, and there is no vaccine or a cure. But it affects primarily young adults, unlike cancer, more like accidental injuries, homicides or suicides, and disproportionately affects our minority populations, especially the black and Hispanic population, and like the toll taken in wartime battles, AIDS takes from our midst many more young men than women, and like many of the past epidemics of our history, such as cholera, leprosy or the plague of Middle Ages, AIDS disproportionately affects the socially disadvantaged or the unpopular segments of our society.

But it is not a disease of specific groups. It is a disease caused primarily by specific behaviors, specifically IV drug abuse, sexual intercourse with an HIV-infected partner, and as I said before, from an HIV-infected mother to her child.

But there is some good news in all this. AIDS virus infection is not spread by casual contact. It is not sweeping across the country like wildfire any more than hepatitis B virus is sweeping across the country like wildfire, and we do know how to stop the spread of AIDS.

We have the knowledge that changing behavior can stop the progression of this epidemic. I would like to introduce the remarks made recently at a conference in Atlanta on AIDS in minority populations given by the former Deputy Director of CDC, my good friend and colleague, graduate of Morehouse College, Dr. Don Hopkins.

As of September 14, of the cases of AIDS reported in the United States, 25,270 were white, 9,911 were black, and 5,678 were Hispanic. Thus, although a majority, 61 percent of the cases were whites, blacks and Hispanics contributed twice as many to those totals as we would expect.

Blacks, who comprise 12 percent of the U.S. population, constitute 24 percent of the AIDS cases. Hispanics, who comprise 7 percent of the U.S. population, constitute 14 percent of all the AIDS cases.

Fifty-four percent of all AIDS cases under 13 years at the time of diagnosis are black, and 24 percent of those under 13 years are Hispanic; thus, 78 percent of all children with AIDS are minority populations. Among cases in women, 52 percent are in blacks, and 19 percent are in Hispanic women.

Persons in minority communities who are infected with the AIDS virus were infected by one of the same ways as everybody else was infected: By sexual contact; perinatally; or parenterally, through IV drug abuse or transfusion, but these are important differences in the proportions of persons infected by the different modes of transmission.

Whereas 12 percent of white men with aids are IV drug abusers or who had sexual partners who were IV drug abusers, fully 40 percent of black and Hispanic men with AIDS fall in that category. Among women with AIDS, the proportion who were IV drug abusers or whose sexual partners were IV drug abusers is 48 percent for whites, 70 percent for blacks, and 82 percent for Hispanics.

Among children with AIDS, 31 percent of white patients were born to mothers who had a history of IV drug abuse themselves or to mothers whose sex partner had a history of IV drug abuse. The comparable percentages for black and Hispanic children with AIDS are 61 percent and 76 percent, respectively.

Looking at it another way, for all AIDS patients reported thus far in the United States, the risk of AIDS among the black population is 2.8 times that of the white, and the Hispanic population, 2.6 times. Among heterosexual IV drug abusers with AIDS, blacks are 20 times as likely to be represented, and Hispanics 21 percent.

Women whose partner—who had a partner who is a IV drug user, and the woman had AIDS, black women are 23 times more likely to be affected, and Hispanic women 29 percent.

Among children who had a mother who is an IV drug abuser and the child had AIDS, again, black and Hispanic populations were 25 and 17 percent—17 times more likely to be affected. Thus, we can see that IV drug users are associated as much with AIDS transmission as the black and Hispanic population in the United States. All of the above data are derived from persons with AIDS.

But the real problem in terms of spread of the disease is from the infected, asymptomatic, infectious persons. When we consider the prevalence rates of HIV antibody among the civilian applicants for the military service, we find that there are 0.8 per 1,000 for whites, 1.0 per 1,000 for Native Americans, Asians and Pacific Islanders, but it is 2.3 per 1,000 for Hispanics and 4.1 per 1,000 for blacks, and among donors examined in Atlanta, Baltimore and Los Angeles, we find that HIV antibodies were present in 2 per 10,000 among whites, 9 per 10,000 among Hispanics and 31 per 10,000 among the black population.

In addressing the problem of AIDS and HIV-infected among black and Hispanic populations, we need to look at the differences between these communities.

As we have seen, the higher rate of IV drug abuse, which is not unrelated to the higher rates of unemployment and inadequate education in the same two groups, IV drug abuses are associated disproportionately with high rates of infection with HIV.

One of the results of this is that nearly half of the black and Hispanic persons with AIDS are heterosexual compared to less than 15 percent of white cases with AIDS. In a certain sense, then, AIDS may be said to be a significant problem in black and Hispanic heterosexual populations.

Among IV drug users in New York City, there are important differences associated with race in a study by Schoenbaum and his colleagues. They found that only 14 percent of white IV drug abusers tested had antibodies to HIV, whereas 42 percent of black and Hispanic drug abusers in the same area had antibodies to the HIV.

Potential barriers to reaching black and Hispanic groups in the U.S. include language, differences in the print, news media and radio channels, may also include a heightened suspicion of government, and a fear of anything which might provide another excuse for discrimination.

In looking at some of the opinion polls conducted in the U.S., some findings emerge. Minority populations are more likely to have misconceptions about how the AIDS virus is transmitted. Many more minorities reported feeling personally vulnerable, fearful and concerned about AIDS.

Another important finding was that when asked in 1986, minority populations, whether they had altered their sexual behavior in a way to protect against AIDS, 4 percent of the whites said yes and 25 percent of the minority populations said yes, which is encouraging.

Well, what is being done? You have heard from Dr. Schuster some of the things specifically directed to IV drug abuse populations. There are major programs designed to reach out into various parts of our community to address the problem of AIDS education and information.

CDC is funding 55 AIDS Health Education-Risk Reduction Programs. 28 percent of these are aimed specifically at the Hispanic population, and 38 percent are targeted specifically to the black communities.

There are five Health Education-Risk Reduction demonstration projects which include specific minority elements. In 19—in the fiscal year 1988, prevention of perinatal AIDS was 6.1 million, and is targeted mainly at black and Hispanic populations in New York City, northern New Jersey and Miami.

The school health initiative includes $100,000 each specifically for Hispanic, black national organizations to help increase involvement of schools.

There is a $4.6 million contract signed a week ago with Ogilvy and Mather Public Affairs, to develop a national media campaign. There is a subcontractor, the Lockhart and Pettus Agency of New York, to help with advertising aimed directly at the black target audiences, and another subcontractor, Sosa and Associates of San Antonio, to address the Hispanic population.

In this fiscal year, an additional $7 million is being made available for AIDS education and prevention among minorities, and in fiscal year 1988, $10 million has been requested, of which $3 million in direct funding is to be awarded competitively to national minority organizations for AIDS education and prevention.

There is a need to promote cooperation. There is a tremendous amount being done by the private sector by voluntary organizations, and we will hear more about that from others this morning. It is gratifying to see the range and numbers of organizations working in this area.

We must ask not only what the Federal Government can do, but also what we can do for ourselves and for those who are infected. Some of what we can do includes helping provide social and medical support, as well as informed advocacy.

For example, AIDS will not be controlled in black and Hispanic communities without more effective prevention of drug abuse and wide access to treatment slots for drug abusers.

Let me just conclude by saying that the effort that will be launched next week for an October National AIDS Awareness/Prevention Month, we expect the joint support from the Hill and from the Executive Branch will bring mention into hopefully every home, every institution across the country during the next month.

We are very grateful for the leadership provided by the private sector, as well as by those like Dionne Warwick, who was here last week, who is contributing so much. We look forward to making this an effort of all of America.

Thank you.

[The statement of Dr. Noble appears on p. 66.]

Mr. RANGEL. Thank you, Dr. Noble.

Again, we will reserve our questions until we can hear from the full panel; and now, from the President's Commission on the HIV Epidemic, and also from my home town of New York, Dr. Burton Lee.

TESTIMONY OF DR. BURTON LEE, M.D., PRESIDENT'S COMMISSION ON THE H.I.V. EPIDEMIC, AND PHYSICIAN AT MEMORIAL SLOAN KETTERING CANCER CENTER

Dr. LEE. Thank you, Congressman Rangel. I appreciate the invitation to address this committee. I thank you, too, Ed Jurith, for also giving this invitation, and I also want to thank my assistant, Peggy DuFore. When people call me now in this matter in New York, they prefer to speak to her, so I prefer to be in the background.

You characterized this task as awesome, and it is. We have a tremendous amount of work to do. One of the problems does relate in the opinion of most of the commission members to the actual deficiencies in the make-up of the commission. I have recommended to the Chairman that we have four advisory councils to make up for those various deficiencies that will occur in any commission.

The first would be a minority council. We have already contacted many people across this country, and I am very happy to say it is impossible to get a no from anybody.

The second council, I am hoping, with the congressional council that could help us and advise us on bills and legislation.

The third council would be from the media. I am most anxious to make friends of the media and to get away from the conflict which we have had up until now. Let them criticize us when our work is

done. It is a little early at this point in time. We also need them for our major task which is the business of education.

The fourth, and not the least, is the bio-medical community. I have the greatest respect for the Surgeon General, and I would hope that Dr. Koop might head such a council, if it is approved by our commission.

I will not read my document. I got a little carried away. It is a bit lengthy, but this document is available if anybody wishes to read it.

Mr. RANGEL. Dr. Lee, at this point by unanimous consent, if there is no objection, your full statement will appear in the record. It is very well written and a very well thought out document.

Mr. LEE. Thank you, sir. The one item in here that I would like to address is the educational issues that come up. The numbers are so striking. Out of the Sunday paper I cut out some figures from the U.S. Business Council. You are talking about 25 million illiterate adults in the United States, and something like 47 million borderline illiterates, making a total of 70 million borderline illiterate adults in the United States of America. Fifty percent of the new jobs that are going to be available will require a high school education, and 30 percent will require a college education. These are massive statistics that have to be addressed on a national basis.

I am strongly in favor of our commission adopting most of the position papers which have already been superbly drawn up by the NIH, by the CDC, by Surgeon General Koop and by the National Academy of Sciences. They address most of the bio-medical issues. I would like to see us adopt them and go on to the bigger problems that revolve around the base of AIDS. This is the illiterate problem. There is only one way out of the poverty cycle other than crime, which Mr. Quinlan will address, and that is education.

We have to do something about this problem, and the second problem is, of course, what we are here today for, which is the drug problem.

A couple of statistics which have been stuck in my mind are that in Rykers Island, which is a holding pen in New York City, 70 percent of the people in there, I am told, have a history of drug use, and 70 percent do not have a sixth-grade education. This is a tough group of people to deal with now. It is too late. I am a cancer doctor, and we would say very nearly that these people have a terminal illness. We have to address this problem before this situation gets to exist.

One of the things that we get into when we look at the bottom of the AIDS problem is what has happened to the families of these people that have gone to prison, to the families of these people who are dropping out of school. I worry very much about the whole welfare program. Why don't we reward the families where the father stays at home, instead of tending to reward a situation where the father lives apart from his family?

When we get down to the solutions on the drug problems, I started off as naive as anybody else, and my instant knee jerk reaction is let's wage war on the drug problem. The police, Miami Vice and a few Treasury agents are not touching this problem, and they are not going to touch this problem. If we want to try to effect the supply side, I think Ed Koch has made some interesting suggestion

about getting a watch plane over Miami, and the Marines and swat teams, and instead of conducting maneuvers in Nicaragua, let's have them in Queens.

However, the drugs coming in really appears to be a rather small percentage of the problem, because of synthetic drugs, so when you get really down into the nitty gritty of this problem, you have to approach the demand part of the equation, and that, of course, is the most difficult part of the equation to address. It is going to take people from this panel to address it. It is going to take leaders from the minority community and from my community to put a stop to the apparent attractiveness of drug use.

I have 100 million ideas about this. I won't bore you with them today. I will finish up by saying that I cannot speak for the commission. I am just one member, but I am intensely committed to this thing and I welcome any and all input from this caucus and members of this committee.

Thank you, very much.

[The statement of Dr. Lee appears on p. 71.]

Mr. RANGEL. Thank you, Dr. Lee. I say that you have got an awesome task, and you are aware of it. If you are going to deal with AIDS, you cannot run away from the IV drug abuser. If you are going to take a look at why people inject heroin into their veins, you are going to look at the homeless situation, the jobless situation. If you are going to look at AIDS, you are going to look at our prisons.

I notice you didn't say you were reaching out to the religious institutions. What shocks me is that in every prison we have some kind of a chaplain who receives orders from a higher authority than we do. I have never heard from any of these people about the AIDS epidemic, the conditions in the prisons, what we should do to make certain that those who leave the prisons are going to make a positive contribution to the community. Instead now we are led to believe that they leave better equipped to be involved in crime, and now more disease. In order to prevent the spread of this deadly disease we have been unable to develop a national strategy because this Administration truly believes that the causes of poverty, unemployment, hopelessness, and drug abuse have to be resolved on the local level, and they have to determine the priority.

Now this national commission is going to report to the President as to how that should be done, and you are right when you say that we have to keep our families together. It is a national tragedy that infants are abandoned, some to just die, and we say that that is a local problem. But even worse than that, when you talk about rewarding the families where the husbands abandon their children because they don't—the family is not eligible for federal participation in giving assistance, you are really getting yourself into a political battle, because we have a House bill that clearly says that we should help the families stay together, and not force a father to leave his home in order for his wife and children to be eligible for Public Assistance.

And so, you are on target, but like me, there are so many jurisdictions that are involved here, doctor, that we don't expect for you to come up with solutions. But the fact is that you have a professional and moral obligation at least to point them out in a national

document and leave it on the steps of the Congress and the President to wrestle with it. Your prestige and the prestige of this committee is on the line, and I can't think of anything that has happened in the last decade that is going to be more meaningful than the fact that people like you, without any partisanship, have agreed to serve, and to put your prestige on the line. We are looking forward to your report. You can count on the support of the minority community, the Congressional community, the media—you will never get rid of them, so they will be around. But, I wish you would reach out to the religious community, because when a kid is born and his parents and community walk away from him, it seems to me that somebody in the churches should be talking about this. And if they can get uptight about the distribution of condoms, which is their prerogative, they ought to look at the moral reason as to why somebody even suggested that condoms should be distributed, since they have full time jobs there, and they don't run every two years.

Mr. LEE. Could I say something else, Congressman. I want to thank you for making me aware early in the game that we do have bipartisan support on this AIDS problem. It is something that I hope does not deteriorate into politics.

Mr. RANGEL. You can depend on that not happening.

Mr. LEE. It will, but I hope that it won't.

Mr. RANGEL. I didn't hear you, doctor. What did you say?

Mr. LEE. I said it will, but I hope that it won't.

Mr. RANGEL. I don't see how it can, because as I understand the work of your commission, it is to investigate and to report. You have no funds, no budget, and no responsibility to resolve this serious crisis. The political question is whether there is a national responsibility or should we leave it to the mayors and to the states. That is not your prerogative.

You are professional and it will be political, but it won't have anything to do with your commission. It may have to do with your appointer, but that is something else.

I want to hear from Dr. Margaret Heagarty, because in addition to her professional responsibilities, she and her staff have the emotional responsibility of being the shepherd of these children, many that are left abandoned. It is always very difficult for me to go into that ward. It is very difficult for me not to reach out and grab one of those children. You have reached out to the community in such a way that we hope that we are able to help some of our community people in helping you to give these kids, not only medical attention but, some of the love which they have every reason to believe that they deserve.

Thank you for sharing this morning with us.

TESTIMONY OF MARGARET HEAGARTY, M.D.

Dr. HEAGARTY. Thank you, Congressman Rangel. I am privileged to have this opportunity to testify before you and this distinguished Congressional caucus about the problems of drug abuse and AIDS as they relate to minority children.

As you know, I am the Director of Pediatrics at Harlem Hospital, and in that capacity, I and my colleagues in the department are

really the major source of pediatric care for Central Harlem. Harlem is in the middle of an epidemic of a new and terrifying disease of infants and children. Let me give you some idea of what has happened over the last two or three years.

Children with AIDS come to us as infants with severe, sometimes lethal, infections, severe growth failure to the point of emaciation, chronic lung infections, and in late stages of the disease signs of severe brain damage.

By 1985, we had identified about 10 such infants and children, of which two or three were hospitalized at any one time. By spring of last year, we had identified 25 or more, and on average had 4 to 6 in the hospital at any one time. By this time we have cared for about 50 or 60 of these children, 8 or 12 are in hospital at any one time. In fact, the total number of children with this infection for whom we are responsible has tripled over the past year to 18 months.

Who are these children? In Harlem, as in the nation, most children contract the HIV virus from their mothers during pregnancy or during the process of delivery. Most of these infected women are either past or present intravenous drug users or have had sexual relations with someone who is infected with the virus, either an intravenous drug user or perhaps a bisexual man. The mothers themselves may have no symptoms of the disease and thus be unaware of their infection. In more than one instance, we have made the diagnosis of AIDS in a child of a mother with no symptoms of AIDS, no history of intravenous drug use and no reason to suspect that she had contracted the infection during intercourse with a man who carried the HIV virus.

The first and perhaps most important thing I want to say to this panel and to you is this. It is easy I suppose, to judge, perhaps even condemn these parents, particularly those who are active drug users. But we who care for them and their children have become much less punitive in our judgments, for we have come to know them and their children, have come to appreciate the tragedy of their lives, to stand in awe before their grief as they watch their children slowly die of AIDS. I assure you that I do know that some of these parents have a form of social leukemia which, for whatever reason, has lost them to the larger society. And indeed, at times, they can be aggravating, hostile, abusive, frustrating people, but they also can be courageous, appreciative, and many, if not most, in their own fashion love their children as you love yours. And so first, and perhaps most important, I plead that you see these parents and their children as victims, rather than villains of AIDS. In the face of such a frightening disease as AIDS, it is tempting to look for someone or some group to blame, to make the scapegoat, but the fact is that AIDS is a viral infection, which is usually lethal, it is not a sin, it is not a crime committed by people or groups of people against others.

Another malignant virus has recently attacked Harlem, a virus which complicates the already difficult problems for children with AIDS and one with which you, Mr. Congressman, have more expertise than I.

In the past year to 18 months we, as all areas of the country, have encountered an enormous increase in cocaine or crack use

among young men and women. But consideration of the children of these cocaine addicts has not received nearly as much publicity as other aspects of the so called crack epidemic. The number of newborns and other children with parents who are addicted to crack and who cannot take care of their children has escalated so sharply that New York City's foster care system has been all but overwhelmed. We now have in New York legions of homeless children, most of whom are children of parents who are addicted to cocaine or the older drug, heroin. Since many drug addicts use more than one type of drug, there is an inevitable overlap between crack and heroin users. Hence many of these homeless children may have been infected with the HIV virus.

Indeed I think that in many ways the cocaine epidemic has caused more damage to the children of Harlem than the AIDS virus. Let me give you two examples. Last year at Harlem Hospital we admitted about 12 or 13 young adolescents with either gunshot or stab wounds, only one of which we knew was involved with cocaine. In the first four months of this year we admitted 13 young adolescents, 9 of whom we knew were drug related. To put it another way, I have been on vacation in the last 10 days to two weeks and in that space of time, we admitted 4 adolescents with gunshot wounds and or stabbings, all of whom I am sure were related to cocaine. The amount of violence in the adolescent population has escalated sharply in the past 18 months that I sometimes feel as if I am running a MASH unit rather than a pediatric service. Or to give another example, in the past few months we have admitted several very small infants with bizarre unexplainable symptoms who on testing were found to have cocaine in their bodies. Our only explanation is that these infants were in rooms in which crack was smoked to a degree that they became toxic by inhaling the smoke, a passive cocaine intoxication.

Since these two epidemics, AIDS and cocaine, have affected the poor more than other groups, they have placed enormous financial stress upon the hospitals that provide care for the poor, specifically public general hospitals like Harlem Hospital Center. Now these hospitals in the best of times are financially fragile because they must rely upon local tax levy funds for survival. The additional burden of these two problems, AIDS and the drug epidemic, imperils the entire municipal health care system of New York and other cities facing similar problems.

The solutions to these two problems, AIDS and cocaine, are at best problematic and complicated, but it is clear that considerable additional resources must be devoted if we are to have any influence upon the course of these related epidemics. We know that the HIV virus is commonly transmitted by needle use in the intravenous drug using groups in our society. We know that methadone is a reasonable alternative for intravenous heroin use. Yet the waiting period for enrollment in a drug treatment program is so long as to discourage all but the most determined. I'm told that there is a 2,000 person waiting list for drug treatment in New York City. We know that cocaine is destroying the families and children of Harlem, yet our efforts to curtail this epidemic and to treat those addicted to this drug seems almost negligent and uncaring in its scope and intensity.

Our existing human services programs were designed in categories that are no longer valid or useful for these as well as other diseases and conditions. Their statutory and regulatory requirements are so complex, dysfunctional, fragmented and disorganized that my professional staff often spends as much or more time dealing with a variety of local, state and federal governmental bureaucracies at all levels as they do providing direct care and support for children and their families. In our zeal to make absolutely certain that no rascals, no scoundrels get something to which we judge they are not entitled, we have constructed paper edifices and barriers that only the most socially organized and educated can master. And we wonder why the most socially disorganized and disadvantaged of our communities have trouble "getting on Medicaid" or registering for this or that program that they tell them they are entitled to. Let me suggest to you, sir, that if you or I had similar problems as AIDS and we had to enroll in Medicaid or SSI or welfare, we too would have problems.

I tell you that these two things, cocaine and AIDS are wrecking an entire generation of children in Harlem. I despair for the lost generation of adolescents I meet on my wards who are addicted to cocaine. As we treat their wounds sustained from the cocaine battles of the street, I recognize that they may very well be doomed unless we find help for them soon. And I know for certain that the children with AIDS are doomed, and I can only hope that we as a society will act to try to protect other children from the slow, premature death of AIDS. We, all of us, professional bureaucrats, politicians, must be prepared to mobilize the resources of this nation in this battle, for history will surely judge us by our actions in the social and human crisis.

[The statement of Dr. Heagarty appears on p. 75.]

Mr. RANGEL. Thank you, doctor, for your eloquent and very powerful statement. From a parochial point of view, would you be willing to have one of your staff people put together the agencies and the names of those people that are part of the network in providing services for your constituents, and I will bring together people from the state and city council to see whether we can find a better way. I think if we can come up with an alternative, that we can expect the support of the mayor; especially in this area, and I would like to believe, since we have more than our share of the problem, that we can get the support of some of the federal people for demonstration grants, because not only does it affect all cities throughout the country, but I think the majority are seeing that they cannot contain it to these communities, and so, perhaps, we can get some people like Dr. Schuster and others to realize that the quicker we go to the battle field and try to get a handle on this, the more secure the nation as a whole might be.

My staff is willing to work with you, but you know which buttons have to be pushed, and you can depend on me putting this together before the year is out.

Dr. HEAGARTY. Thank you, Mr. Congressman.

Mr. RANGEL. We leave briefly this area and go into our prison system. We have with us J. Michael Quinlan, who is the Director of the Federal Bureau of Prisons, and we welcome his testimony this morning.

TESTIMONY OF J. MICHAEL QUINLAN, DIRECTOR, FEDERAL BUREAU OF PRISONS

Mr. QUINLAN. Thank you very much, Mr. Chairman. Mr. Chairman and members of the Select Committee: I appreciate this opportunity to testify about my concerns regarding AIDS and drug abuse among inmates confined in the Federal Bureau of Prisons. I would like to introduce to you at this time the medical director of the Federal Bureau of Prisons, and Assistant Surgeon General in the United States Public Health, Dr. Robert Brutsche, who is on my immediate left.

Prior to June 15th, 1987, the Bureau of Prisons tested for the HIV virus in only those inmates exhibiting clinical symptons of the virus. Based on the President's initiative and Executive Order in June, we expanded testing for the HIV infection to two groups of inmates: All newly sentenced inmates and all inmates within 60 days of release are tested for the HIV virus. The group of newly sentenced inmates will be retested in three months, in six months and every six months thereafter. Results from the retesting will give us information about the risk of acquiring the infection during confinement.

The Bureau of Prisons has adopted a system developed by the Centers for Disease Control for defining different stages of the HIV disease process. We monitor all inmates who have been identified as being at any stage in the disease and attempt to ensure their anonymity. We can classify three stages of the disease, end stage AIDS, the most advanced form of the disease; an intermediate stage in which inmates have less severe symptons but often require intermittent hospitalization; and the first stage, consisting of HIV positive inmates with no symptoms.

Out of a total federal inmate population of 44,000, we currently have 33 inmates with end stage AIDS. Our AIDS policy consists of treating these inmates at one of our medical centers where they can be closely monitored and treated. Many of the patients who are at the intermediate stage of the disease are also in one of our hospitals for treatment until their clinical condition improves. Inmates who have milder symptoms are treated at their local institution and remain in the general population.

Inmates who have tested positive for the HIV anti-body but have no disease symptoms are continued in the normal prison environment. Only medical personnel and other key personnel in the prison are made aware of positive results on a need-to-know basis.

We have established a major education program for inmates and staff based on what is known about AIDS. We believe education to be the most important step to be taken in the attempts to contain the effects of this disease. All staff and inmates are required to view an AIDS training film which stresses basic information about AIDS and emphasizes that the disease is transmitted by sexual activity and intravenous drug use with contaminated needles.

Mr. Chairman, I would like to turn my attention to drug abuse among inmates, and especially its relationship to AIDS. As you know, intravenous drug use with shared needles is a major source of infection for AIDS. Among newly committed inmates, this appears to be a far more common source of infection than homosex-

ual contacts. Because of this well documented relationship, we must be constantly vigilant for the occurrence of intravenous drug use among inmates. We also have the responsibility to offer former intravenous drug users, as well as any drug user, counseling and drug treatment programs.

As part of our policy of detection and prevention of drug use among prisoners, we conduct random drug tests on suspected users as well as on a group of randomly selected inmates. Tests detect barbiturates, cocaine, opium, amphetamines, and other drugs. We conducted 45,000 tests in 1985, 53,000 tests were conducted in 1986, and through the third quarter of 1987, we have conducted 45,000 tests. The percentage of inmates testing positive for drug use has dropped from 7.43 percent in 1985 to 4.5 percent in 1986. This year we are running at about 3.5 percent positive testing for drugs.

Among those who tested positive in the current fiscal year, 56 percent were positive for THV marijuana, 18 percent for cocaine, 16 percent for opiates, and 18 percent for amphetamines, barbiturates, and other drugs. The Bureau of Prisons is making significant progress in reducing drug use by inmates, as can be seen from these testing figures. Based on the drug testing results alone , it is difficult to surmise the extent of intravenous drug use. We know that a small fraction of inmates sometimes use opiates and other potentially injected drugs but we do not know the exact method by which they take these drugs. We believe it is difficult for most intravenous drug users to continuously evade both the drug testing and the random searches of their living areas for drug paraphenalia and other contraband.

However, because this surveillance program is not complete, it is also important to educate inmates about the extreme dangers of acquiring an HIV infection through the use of needles.

Mr. Chairman, I know you are deeply concerned about the effects of drug use and AIDS on the minority community. I would like to turn my attention to some of those issues as they relate to the federal inmate population. Blacks and Hispanics comprise 51 percent of the current Bureau of Prisons population. Of the federal inmates who have been identified as having some stage of the HIV disease, 78 percent are black or Hispanic. As reported in the August 17, 1987 issue of U.S. News and World Report, minorities make up less than one-fifth of this nation's population and represent over 40 percent of the 38,000 AIDS victims. Among federal inmates, we find that minorities comprise 82 percent of AIDS patients, 83 percent of the intermediate stage patients, and 74 percent of those who test positive for the disease but have no symptoms.

Through counseling and interviews, we try to determine the most likely behavior which placed the AIDS infected offenders at risk prior to their incarceration. As you are aware, the dominant factor in this country is homosexual behavior, intravenous drug use is the next highest risk behavior. As indicated earlier, inmates entering the federal prison system show a dominant intravenous drug use, 73 percent, followed by homosexual behavior, 9 percent. The other 10 percent consists of a mixture of bisexual, heterosexual prostitutes and those with a history of multi-sex partners, hemophiliacs, and those affected through blood transfusions. This holds for minorities as well as the white infected population.

As I am sure you appreciate, Mr. Chairman, the two most compelling problems facing the Bureau of Prisons in the next several years are the impact of population increases on an already strained system and the large potential for increase of the HIV infection. We have tried to anticipate this challenge by a comprehensive proposal that monitors the incidents and its spread. Education and counseling programs are essential. We are also constantly reassessing our policies in light of new information about the disease and its prevalence in our population.

That concludes my statement, Mr. Chairman.

[The prepared statement of Mr. Quinlan appears on p. 81.]

Mr. RANGEL. Thank you, Mr. Quinlan. And now we hear from an inmate of that system, our former colleague and former Member of the House of Representatives who has been willing to come here and share his views with us, former Congressman George Hansen.

TESTIMONY OF GEORGE HANSEN, FORMER MEMBER OF THE HOUSE OF REPRESENTATIVES

Mr. HANSEN. Thank you, Mr. Chairman. I deeply appreciate your invitation for me to appear before you today during this special part of the Congressional Black Caucus weekend. Your letter to me of September 8 clearly spelled out the mission of my testimony, which is, of course, your desire to deal with the problem of AIDS in prison as well as the health and budget impact upon the public in general.

I had prepared a comprehensive statement, but just last night I found out this was to be more of a panel than regular testimony, so I am going to abbreviate a bit and take it in three brief parts

One, Mr. Chairman, will be to talk about why we are here, the second is to talk about some of the things I have observed, and third is to talk about solutions.

To properly accomplish this, I hope we will be able to examine a broad range of prison problems and procedures as they relate to the ability of the nation's law enforcement, legal, judicial, and prison operations to cope with the spreading AIDS epidemic. Again, let me emphasize that the full thrust of my appearance here today is to deal with your stated mission, the impact of AIDS in our prisons.

I am delighted to be in the company of this distinguished panel and with so many of my friends and former colleagues, some who, like yourself, have long been working with AIDS and prison reform and other related government oversight problems.

Mr. Chairman, there is a lot wrong with the system and also a lot that we can do; and thanks to you, I am privileged to be here to raise a bit of hell and hopefully get some action. It hasn't been easy for either of us for me to be here, let alone to speak freely and fully on the issues. You recognized the unique qualifications I have to testify by your kind invitiation—qualifications as a prisoner and as a veteran of Congress. This isn't our first time together in such a testifying relationship. Several years ago as Chairman of the Internal Revenue Service Oversight Subcommittee of the Ways and Means Committee, you held landmark hearings on IRS abuses right here in this Chamber, and I was one of your lead-off wit-

nesses. From that time I have respected well your ability to conduct a fact-finding meeting and draw out the core issues. So I do deeply appreciate being included in today's hearing.

I have a unique situation in that I have seven terms as a Congressman and have also been held in seven prisons and jail circumstances during the past 15 to 18 months from Omaha, Nebraska to Alexandria and Petersburg, Virginia. These were both federal and local facilities, and I have seen the best and worst first hand. It is a profound educational experience but I really don't recommend it for a Congressional Junket.

Mr. Chairman, It is hard to know where to begin, because there are such serious problems. Perhaps it is best to back up just a second and tell you how I feel about racial matters and some of the situations that you have to deal with. There is a great deal of racism in the prison system. In fact, the statistics Mr. Quinlan just pointed out clearly show that it is the minority groups who suffer the worst from this dread disease AIDS at this point. Therefore it is indeed fitting that you address the AIDS problem here on this particular commemorative weekend, and address it specifically for minorities, even though it is a disease that hits everyone.

I have watched when prison officials bring back a person from a so-called parole violation and I have seen some of the flimsy reasons they give when they bring them back. They sweep them off the street because somehow they haven't got a job, and it is very difficult sometimes for street people to have jobs, because of their lack of qualifications or whatever. It then takes them months to be heard on the matter. They sit in prison waiting for the Parole Board to come around and take action again. I have seen this kind of injustice in so many ways, and I feel that because of education, because of background, because of the street circumstances, a lot of these kids grow up never having a chance to start with; and they don't really have a chance after they are grown. This disturbs me. It disturbs me very much.

Then I see the half-hearted way they address the AIDS problem, the idea that we are just going to partially test, but not really do anything to protect people, and that scares me. Because while they are dabbling at testing and playing around, people are dying. A lot of people are dying. One is too many, but thousands is disgraceful, and that is what is happening.

Let me tell you a few examples of what has been happening in prisons by my own observation. First, you see these federal indoctrination films that Mr. Quinlan talks about and they make valid points. Avoid the intravenous use of drugs, avoid homosexuality or find some way to practice safe sex or whatever. These are the points they make. But, Mr. Chairman, these films and advisory memos also tell you to avoid the common use of razors and fingernail clippers, and situations where you can get blood on you and become infected. But, here's where we find the lies and the cover-up, because these same federal officials will then very piously tell you that they don't have common razors in federal facilities. This is absolutely untrue and can be proven. Common razors—even disposables—are used frequently in high security areas of federal facilities and in cooperative facilities were federal officials park federal prisoners such as county jails. I have been in these places as a

federal prisoner and know those common razors are there. That is why I have grown a beard to protect myself and also to make a point for the public of the danger of contracting AIDS in prison.

Sometimes, as Confucius said, one picture is worth 10,000 words. Well, the point is, I wasn't about to use one of the common razors in those county jails. I don't know if anyone understands what is going on, but jails generally use those old metal Gillettes with two edges that you adjust in the handle. The jailers take the adjuster out so it can only be screwed up with a screwdriver. That's so that prisoners can't get the razor blade out. But most of the time the jailers don't screw it in tight, and the blade stays out straight. I can tell you that you get a good peeling if you try to shave with that contraption, one that draws blood. Everybody has to shave with the same razor. Even worse, some people aren't very careful about the way they clean things after they shave, and disinfectant is almost unheard of in most jails. This is a very real problem, and the Federal Government cannot piously, like it so often does, sit back and say we don't use common razors.

They will lie right to your face that they are not doing these things, Mr. Chairman, but they are. The feds do it in their own facilities and they are involved with the counties and other jails in every corner of the nation in the use of the common razor and other sanitary nightmares. I get letters back and forth from prison officials at the highest levels who say, "oh, we don't do these things." But they do. Prison officials say you can't pass AIDS through the food service, but let me tell you about the food service. It is bad enough when you are not even talking about AIDS. They won't clean things like the deep fat fryers until it's loaded with rancid grease and 40 or 50 roaches in the bottom cooked to a crisp. And that is what they cook the chicken in and french fries. And the chicken they serve is meat purchased from outdated food operations, some even labelled, "Do not use, not fit for human consumption. It is a miracle that you haven't had all kinds of illness in prisons, not to mention AIDS. But if prison officials can't handle basic sanitation and health matters how are they going to handle an epidemic like AIDS? That is what worries me.

In this prison where I am, I watched officials bring a prisoner back from giving a kidney to save his son's life. Now this is just one example, but it is pretty glaring. In fact, it was in the national press recently. Here is a person who went out with the blessing of prison officials to give the kidney. But when he came back they hassled him unmercifully. He was ordered back to prison the same day he had his stitches or staples removed. They absurdly charged him with being out without authority and staying too long, a contradiction in itself. He did have permission and also telephone tapes to prove his legal position, but they were so hell-bent to throw him in the "hole" that nobody wanted to listen to him. They made him climb two flights of steps, despite that fact that this doctor, who had not released him, said he absolutely shouldn't climb stairs because he had an unhealed incision a foot long in his side. They made him climb the steps and threw him in the "hole," a cell cooking in the summer heat at 110 or 120 degrees. He was given a mattress-type pad that was a half-inch thick and still moist from the last person being there sweating. He couldn't even lay

down because his lungs were full of water. It is indeed strange that he didn't catch an infection and perhaps die.

The prison doctor or prison's physician assistant—I should say—wouldn't look at him because he hadn't been released by his doctor, and , of course, he couldn't be seen by his own doctor. So he had no medical care. Nobody would look at him for a period of some 18 days.

The point I make is that these government officials would throw him in the "hole," as a reward for doing a life-saving humanitarian act for his son, instead of allowing him to return safety to recuperate properly. I think this is absolutely barbaric and inhumane, this kind of behavior. But to go further, to translate it into the AIDS situation, it is too often true that the way prison officials deal with sick people is to throw them in the "hole," especially when they don't know what else to do. So, what happens when a person is identified as having AIDS? You know the answer. They pull him out of the general population and throw him in the "hole." The "hole" is splendid isolation.

Mr. RANGEL. Are you saying, because I was wondering how you were going to get back to the subject matter, that when a prisoner is identified as having the AIDS virus, that they throw him in the hole?

Mr. HANSEN. That is correct. They isolate them from the general community, and they throw him in the hole and that is where he stays until they decide what to do with him. That is discrimination. They need to have some kind of facility, Mr. Chairman, in the prisons to take care of people so that they can at least have equal facilities, if they have a disease. They shouldn't punish a person for being identified as having AIDS. That's the cruelest form of discrimination.

Mr. RANGEL. Did the Federal Bureau of Prisons leave or just the director? Let me say this. I am sorry to interrupt your testimony. I know you went at great lengths to prepare that written document. If you would be kind enough to leave your written document, I will see that it is adequately transcribed, and to get a copy to you, and in addition to that, because I don't mean to cut off your testimony, I wish you would make specific recommendations that could be followed by the committee with jurisdiction.

I have talked with Congressman Kastenmeier, Congressman Don Edwards as well as Congressman John Conyers, and so we want you to know that the questions you are raising are not going to go unanswered, notwithstanding the fact that at this point in time Director Quinlan has left us. You many proceed.

Mr. HANSEN. Thank you, Mr. Chairman.

My point has to be that prisons officials can smile all they want, they can test all they want in random ways, but, Mr. Chairman, when they test people in this so-called limited policy of testing, only test them coming in and going out, it not only won't work, it's a hoax. What good does an entry test do when the new prisoner is then thrown into the untested general population. One specific piece of legislation would be that when you have people confined—I am not taking about the general population of the United States—but when you have people confined where they have to use common facilities and you don't know who your neighbor is and

what he has been in to and whether he is infected or anything else, that everyone ought to be tested immediately.

There are not that many people to prevent full testing. Then, of course, the new ones coming in ought to be tested before they are mingled. This helps in two ways. One is potential liability to the government. Remember the Agent Orange fight resulting from the war in Vietnam. A lot of people complained about exposure and they finally succeeded in bringing action over the years to establish government liability and force compensation, a very expensive obligation on the taxpayers. In this case, you have people who can come in clean, pick up a deadly disease while under federal jurisdiction and become a liability to the taxpayer. In effect, they pick up a "death sentence" from AIDS in prison. If a prisoner tests positive for AIDS on the way out, but they haven't had a test beforehand, how do you determine whether it is their fault or the government's fault? There is a question of liability.

Mr. RANGEL. The prevailing view, Congressman, is that unless there is homosexuality or IV drug use, or some blood contact, that just being in the prison population does not make you vulnerable.

Mr. HANSEN. Mr. Chairman, if I can interrupt, I think that is bunk and clearly leaves the government vulnerable, not to mention the fear and hardship it imposes on prisoners and their families. Any time the medical field can't agree on what the total cause of AIDS is, then what they have is a panic situation. You have cause for riots in prison because people don't know for sure. One doctor says maybe you can get it from a mosquito bite, while others say, "no." Another doctor says you can get it from other kinds of causes, while other professionals disagree.

Sure, the main causes they talk about at this point are so-called "dirty needles" and "dirty sex," but the point is that there are many other known and suspected causes. There is a so-called "clean sex." And also the fact that you can be around a person in an accident and get his blood on you while trying to give first aid—and the problems of hemophiliacs and drug transfusions. Then they tell you not to use a common razor, on the one hand, but that's what you're furnished, on the other. And then they will have a person who has AIDS remain in the general population of the prison while practicing a life style including long-long fingernails which scratch and draw blood of others when they play basketball. When they find out he has AIDS these people who were scratched, go around scared to death because maybe, since they were scratched and blood flowed, and prison information warns against common nail clippers that they might have it themselves. Until medical and government officials of this country can decide what really causes AIDS and what won't cause AIDS, I think you have a serious problem, not of what is always real, but of what is perceived. In order to give comfort to people and reduce fear, tension and violence, proper sanitation and practical preventive measures must be provided in an atmosphere of honesty and common sense.

Mr. RANGEL. What recommendations would you make?

Mr. HANSEN. Beside the recommendations I have made for full and complete testing and an end to inhumane and discriminatory practices, Mr Chairman, the most important recommendation I have to make today, is alternative sentencing. Unload the jails.

Send people home. Limit the expense and liability to the taxpayer. If people are trustworthy enough to report voluntarily and go to these so-called "honor" camps, these level-one camps, why keep them there at $20,000 to $30,000 a year at taxpayers' expense, when they could be home, in "house arrest" or some other type of acceptable punishment program. Then they would be working, providing for their family, taking their family off welfare and that keeping the family together, instead of saddling them with an impossible burden and make them run up and down the road to visit prisoners on weekends, seriously disrupting children from their education, church activities and ties with their friends

California is a state which has been experimenting very strongly with keeping people at home because of the grave threat of AIDS and overcrowdedness in prison. This is very progressive, but it seems to me that the Federal Government in so many ways requires things of the state system, the local system, and private enterprise, that the feds aren't willing to do themselves. The Federal Government is often the least quick to respond to crises and do things that are progressive. Certainly, in the face of these crises in overcrowded prisons and AIDS, the Federal Government ought to lead out in emptying the Nation's prisons wherever it is possible of first-time non-violent offenders, people who are not a threat to the community, and who should be taxpayers, not tax eaters.

Mr. RANGEL. What is your status as it relates to alternative sentencing?

Mr. HANSEN. My own status? Yes, I am one who should be working, not loafing. Of course, I am about out anyway, so it doesn't really affect me. I will be out Thursday.

Mr. RANGEL. But why were you actually incarcerated as opposed to getting one of these "honor" camp type of things?

Mr. HANSEN. I am in, I guess, one of the so-called "honor" camps, the level-one camp, but the point is, it is like a nursing home. You sit around with able-bodied people doing nothing. Now if they haven't learned their lesson, as they were brutalized in the court procedure, in the high cost of paying an attorney, in losing their job or business, and in being publicly and even sensationally exposed for whatever they have done, if they haven't learned a lesson by then, they are incorrigible

Even if you want to send an offender to prison a few weeks to let him know what the realities of life are, that is fine, but the kind of inmate I speak of basically ought to be out of there. He ought to be at home where he is safe, or at least safer, and where he can lead a productive life.

Mr. Chairman, there are a couple of other things. As I have said, I think full testing is important in a confined circumstance, and I think legislation in that direction ought to be strongly considered.

I also think we ought to have civil rights legislation of a sort to make prison officials stop punishing the sick by throwing them in the "hole." There are enough federal prisons around the country that they can create fair and equal facilities at any level to provide for the sick. If a guy is a real machine gun Kelly, well, there are places you can put them. If people are paper criminals, well, there are proper places you can put them. You don't have to put different levels together, you can keep them separate. Some people don't

like the idea of separating AIDS victims from the general population, but Mr. Chairman, there are people who are AIDS victims who can't stand being in the same room that is comfortable for you and me, because they are chilled by the air conditioning——

Mr. RANGEL. We are trying to see whether we can get some answers to some of the questions that you raised immediately. Would you proceed?

Mr. HANSEN. The point is, Mr. Chairman——

Mr. RANGEL. Excuse me one moment.

Mr. HANSEN. The point is, Mr. Chairman, that an AIDS victim will catch pneumonia in an air-conditioned room sometimes because of his limited immunity or no immunity, where a normal person would be comfortable. And there are times when, for the protection of the people who are not ill, as will as for the protection of people who are ill, that separation may be in order.

Mr. RANGEL. Let me say this. I don't know, but certainly you have been closer to the problems that arise when people are forced to live in very close proximity, and there is no question that this can make people vulnerable to the AIDS virus, and you do raise a very serious question as to whether or not identification of having the AIDS virus should be treated in a punitive way, and you can describe later, if it is not in your papers, as to what being thrown in the hole is.

I am glad to see Bill Hughes is with us this morning. You have been very kind in restricting your testimony to the subject matters of this committee, but I don't see how we can avoid looking at the question of prison reform, especially if we are talking about prisoners that have contracted the AIDS virus or the disease. Because of poor conditions where it is perceived that the prison is being exposed to a disease in a way that is not true of the general public.

I did not know you were leaving on Thursday, but I do hope that you will continue to take advantage of the set-back and bad experiences that you had in prison, of the fact that you are well-known to the media and certainly nationally, perhaps for reasons that you would not want to be known, but nevertheless, take advantage of that platform to see whether or not your voice could be heard in a way that other people who are less easily identified would not be. I can assure you that as Chairman of this Committee, knowing Bill Hughes as well as I do, that we will be looking into this.

You didn't mention the two things which I had thought would be a problem, that is the degree of drug abuse in the prison, and the homosexuality by consent or otherwise that we hear exists in some prisons. We understand fully that this is more common in our state facilities than federal, but you heard and have seen—or could you share any light on whether these activities take place at all?

Mr. HANSEN. They do take place, Mr. Chairman. There are a lot of records that show that it takes place, both homosexuality and the drug abuse problem. However, I might say that the way prison official are going in trying to identify it, is actually driving it underground. Worse than that, it is hard for them to know the extent of prison AIDS and its courses becaue they are actually forcing employees to lie and cover-up on personnel documents and reports. This can be proven.

First, the reason I say that is this. If random AIDS tests were given, officials would be pretty much able to know what is going on, but when they say they will only give a test, and that is the way it is done now, if you admit culpability that you have been messing around with a dirty needle or homosexuality. That puts a prisoner in a position to be punished, or at least he will think it does. So, unless a prisoner will admit to some culpability, he can't get a test. Prison officials try to deny that they refuse tests, but they continue to publicly lie about this.

Few prisoners want to invite trouble, so officials are defeating themselves in terms of ever knowing or finding out what the full extent of homosexuality or drug use really is. Why a person is forced to admit wrong doing to even get an AIDS test is difficult to understand, and stupid.

Mr. RANGEL. Bill Hughes is with us, and it is not a subject matter which I have too much knowledge of, and I will be working on this, mainly on the state level, but I will ask Chairman Hughes if he has any questions specifically as it relates to the federal prisons.

Mr. HUGHES. Thank you, Mr. Chairman.

First let me congratulate you on convening this hearing today. I think it is very timely and useful in trying to deal with what is certainly a very very serious problem and potentially important serious in the years ahead.

I want to say hello to my former colleague. You seem to have trimmed down considerably, and it is good to see you. I am concerned over a number of things that I read in your statement, and I apologize for not being able to be here for all of the testimony. I have heard some of it.

I am concerned over your suggestion, number one, that you are forced to use the same razors. That is one of the reasons why you grew a beard in prison, that the same razor, if you cut yourself, is being used by a host of other prisoners. There is some question as to whether or not some of those might be carrying the AIDS virus, and I understand that is a particular concern of yours.

Second of all, that the prison authorities isolate "in the hole" as you indicate those that are suspected of having AIDS. I wonder if you would describe for us those that end up "in the hole" and what it means "in the hole."

Mr. HANSEN. Well, the hole is generally a set of hold-over cells used for discipline or when they are moving someone somewhere. But they have very limited facilities. It usually means isolation or being with one other person. It's not always very clean and sometimes very filthy, particularly in non-Federal facilities. If you foul up and do something wrong, or even if they think you did something wrong, in a level-one camp such as where I am, the officers run you right across the street in handcuffs and chains and toss you into this place. Air-conditioning is virtually nonexistent and in the summer it will be 110 degrees. It's like a sweatshop; I guess to sweat some sense back into you. But it is used very liberally and oftentimes very unfairly, because they hit you first and ask questions later.

Unfortunately this treatment can be extremely cruel when they do it to a person, who is not well. A classic example is the person,

who I mentioned earlier, who had just given a kidney to save his son's life. Officials, who couldn't get their acts together threw him into the "hole" for two or three weeks while he was trying to heal and the foot-long wound in his side was still leaking. They put him in that sweat cell with a sinkful of feces which they didn't clean out from the last prisoner, and on a one-half inch thick cloth-covered mattress which was still wet with the sweat of the last person. These officials will also throw you into a cell alone with an AIDS infected homosexual and other equally cruel or stupid practices. That scares the devil out of people. This is what is happening. They can say all they want about their practices in handling prisoners and the pretty films they have. But, Mr. Chairman, these officials don't—they don't necessarily practice what they preach.

Mr. HUGHES. What facility are you talking about in particular?

Mr. HANSEN. What is that?

Mr. HUGHES. What facility? Where did this take place what you describe?

Mr. HANSEN. Well, every jail, every prison usually has a place where they throw people for disciplinary action.

Mr. HUGHES. Where did you see this in particular or come to have direct knowledge?

Mr. HANSEN. The fellow I mentioned, a person by the name of Tom Williams is one example. His story was in Jack Anderson's column a couple days ago. I am personally familiar with him and observed what happened to him, and everybody is pretty disgusted about this. But again, he isn't an exception; this kind of thing is not unusual.

Mr. HUGHES. Do you have firsthand knowledge, though, of these conditions? Do you have firsthand knowledge?

Mr. HANSEN. Well, I haven't been in the hole itself, thank God, but I think I have had enough accounts from it from people I consider to be reliable, and they have been common accounts to know that that is the case, yes.

Mr. HUGHES. But you do not have firsthand knowledge yourself of these conditions existing and that the prison authorities put individuals, for instance, that have just undergone an operation or otherwise——

Mr. HANSEN. Of course, the knowledge I have is firsthand. I know the man. I saw the incision in his side. I know where he went. I have talked to him and witnesses from the scene, both staff and inmates. I don't know how much else I could do, except go over and sit with him. Bu, I have also been in those "holes' myself as a federal prisoner in county jails.

Mr. HUGHES. With regard to shaving, what is the practice in the prison system to your knowledge with regard to the use of common razors?

Mr. HANSEN. Well, normally in the Federal prisons you can either purchase razors, safety razors, from the commissary, or, if you don't have the funds, they will distribute disposables and you can use those. So the Federal system generally, except for certain exceptions, practices what it preaches about keeping clean razors. The exceptions include the practices in non-federal facilities used extensively by the feds and the "hole", where disposables are reused without question.

Mr. HUGHES. Because that was my understanding that in the prison system, the Federal system, that they do encourage in fact the use of disposable razors, that if you can't afford to purchase your own razors, they will provide disposable razors and that disposable razors are generally used in the prison system at the Federal level. I don't know about——

Mr. HANSEN. See, the Feds use the city and county jails very much. I was, for instance, held for one month over in the Alexandria—the old Alexandria jail—which they were letting run down while they were getting moved into a new facility. Here they were passing the common razor around. I was a Federal prisoner, but I was in a county jail, and that happens all the time. All I am saying is that the Federal Government, in its own specific facilities, generally does what it says regarding the common razor, but it works with all kinds of non-federal people who don't have the exact same standards.

Mr. HUGHES. I understand, and I understand that we do use county and state facilities from time to time as holding areas, often we house Federal prisoners in county facilities for fairly long periods of time and what you are suggesting is, while the Federal officials may have standards that are acceptable and that encourage good hygiene and are rather productive with regard to such things as shaving, that that may not necessarily be the case with Federal prisoners in other institutions.

Mr. HANSEN. That is true, and also, as I pointed out earlier, in the Federal institutions as the security gets higher, or in a place like the "hole", there is definite slippage in use of the common razor, Mr. Chairman.

Mr. HUGHES. Yes, I am aware of that and, in fact, have some knowledge that that occurs and that does give me some concern. I am sorry Mr. Quinlan is not here to respond to some of the questions that I had with regard to some of your statements. But you brought to our attention something that we should in fact pursue a little further. We thank you for that.

Mr. HANSEN. One other thing, Mr. Chairman, when they talk about AIDS in the food. Mr. Quinlan wrote a letter to me saying, among other things, that AIDS is not food borne. Well, I don't quarrel with that, but here is the problem. The other day it was announced in the press that a USDA meat inspector, one out of some 7200 had been suspended from work because it was found that he had AIDS. Apparently it is not because AIDS can be transmitted in the food, it is because knives are used frequently, and as cooks often do, they can cut fingers and their blood can get into things. That is the problem.

Now we had an AIDS victim in Petersburg this summer who died, a similar example. He too was working with food in the bakery. It wasn't long until everyone knew, people aren't dumb. And they know that blood transmits AIDS all right, and that you don't know where that blood might be, especially if a person cuts himself. That scares them and it can cause riots. If you want to keep away from prison riots and violence you don't scare people and make them insecure. And it gets worse because when the dying victim was being taken into town, into the Petersburg medical facility for treatment, the prison officials didn't level with the

town medical officials and doctors about what kind of patient he was. They billed him as a pneumonia patient when he had AIDS, and it has the local medical facilities pretty uptight about ever dealing again with the Federal institution because they don't feel they can trust them on the type of medical cases they are getting. Of course, this person died and there was a story on some of this recently in The Washington Post.

Mr. HUGHES. Let me ask you along the same line that we were pursuing previously—with regard to practices in the Federal system, I want to deal with your experience, not what somebody else told you, but your experiences. What is the practice when somebody is suspected of AIDS? Does the system—does the prison system provide expeditious testing at that point?

Mr. HANSEN. The system may provide fairly expeditious testing for AIDS if you will admit to homosexual relations or use of drugs with a dirty needle. Otherwise, it's a hassle with no guarantee of a test now. I have had an AIDS test because I am due to leave the prison. So under the limited test program I received the test. One of the more interesting things, Mr. Chairman, is how the physician's assistants put the gloves on to protect themselves, but they don't change the gloves between patients to protect the inmates unless you demand for them to do it.

Now, dammit, you wouldn't go to your own doctor and neither would anybody else in here if he wasn't changing his gloves between patients. Now officials try to say this doesn't happen, but I have seen it happen from, my own experience. I kept the Band-aid to show how there was actually a secretion of blood in my case which means that when the technician got his hands down there inserting the needle, closing the wound, and putting the band aid on, his gloves had blood contact. They he moves on to the next person and repeats the process. If he doens't change gloves, he's passing blood from patient to patient.

Now, these people aren't practicing good hygiene. The same goes for the people who are doing the shakedowns and patdowns, and so forth. They all wear the rubber gloves to protect themselves and they often get into body crevices. But do you think they will change those gloves before they go on to the next person? Now, that kind of stuff is pretty slip-shod.

Mr. HUGHES. Now with regard to the people who test positive for AIDS virus, what is the practice, to your knowledge, to your personal knowledge?

Mr. HANSEN. They like to keep them in the general population, but only as long as they can keep it bottled up. Once the word get out—and usually a guy will say something himself—the officials do crazy things. It is hard to keep that kind of secret. Here's what happened in my own dorm. They had a person who, after an unforgivable delay, was identified as having AIDS. He had never been very silent about saying he had a brother who had AIDS, and that if his brother had AIDS, he had AIDS. Prison officials, had a medical file several inches thick on the man from a state institution and they still put him in the dorm on a routine basis with no testing or precautions. Finally they found out he had AIDS. I don't know what reason—dirty needles, or something. Anyway, he wore unusually long fingernails and played basketball and was drinking

out of other people's water jugs at work and other things like this. Now maybe people can't get AIDS from this, but you try to convince them of this. It scares the devil out of them, especially when there is nothing that says you can't give AIDS when you scratch a gash on somebody on a baseketball court with long fingernails and, draw blood. So that is the problem. When this AIDS victim was taken out, everyone had the shudders.

Now, the warden put out a memo saying you can't get AIDS from a mattress or such thingss but prison officials are so nervous about holding down the tension that they will throw the AIDS victim's mattress out anyway. And it is not only just in the dorm where this happened, but over in the "hole" and everywhere else, as well. They throw them out in the dumpsters just to give people a piece of mind and hold down the tension. It is the same way when Mr. Quinlan writes me a letter, or the Warden down there puts out bulletins to the inmates, saying you can't get AIDS from food, but then all at once you read in the paper that the USDA pulls people with AIDS out of food processing operations.

The point is, until there is some consistency, on the part of government agencies and in the opinions' of different doctors as to what causes AIDS and what practices are truly safe, then you have got this problem of what people perceive which is often bigger than reality. A crisis with violence and riots can be caused by what people think, whether it is real or not prison officials are sitting on a powder keg and appear to be lighting matches around the fuse.

Mr. HUGHES. I understood and I do appreciate your responding to my questions. Thank you very much.

Mr. RANGEL. Thank you, Mr. Chairman, and I want to thank you, Congressman Hansen, because I was sharing with my colleagues on the panel, the perception is something we have to deal with. We have that problem in our public hospital system among employees that are exposed to some of the patients so I can understand how someone that is incarcerated with other fears and other insecurities could perceive that anything that they do in the breakage of skin would make them vulnerable. And again, I hope you work with your former colleagues in seeing whether we can take advantage of the experiences that you have had in a very positive way, but it took a lot of courage for you to come here to testify today, and also, while this view may not be shared with everyone on the panel, the fact that you did not use this as a forum politically or to involve some of your personal experiences, but rather stayed with the subject matter—I didn't expect anything less of you, but there was some that thought some risk was involved and you have reinforced the thinking of the chair and staff, and I thank you for doing that.

Mr. HANSEN. May I respond briefly, Mr. Chairman? I have to say that I have too much respect for you to use your forum for something other than what it was designed for, and I do appreciate the opportunity of being here.

I would also like to say that when I took my AIDS test, I had to go ask for the result. There needs to be disclosure at least to the person involved. And there is another item that needs to be discussed when this Administration or anyone else says that AIDS is basically a state or local responsibility or some other responsibility

which isn't Federal, they're deadwrong. Believe me, AIDS is everyone's responsibility and we had better be doing something about it at all levels. Your efforts are doing this, Mr. Chairman, and I am pleased to be here and proud to be asked to help. I thank you for this opportunity and enclose my legislative recommendations which you requested which appear on p. 110.

Mr. RANGEL. Thank you again, and we wish you well.

Anthony Travisono is the executive director of the American Correctional Association and his organization deals with the local and state, I understand, as well as the Federal systems.

Your testimony will be entered into the record in its entirety and we thank you so much for sharing your views with us.

TESTIMONY OF ANTHONY TRAVISONO, EXECUTIVE DIRECTOR, AMERICAN CORRECTIONAL ASSOCIATION

Mr. TRAVISONO. Thank you, Mr. Chairman, for allowing me to speak for a few moments. I will not try to go through any of the written testimony except raise some of the same questions Mr. Hansen has raised.

We do not have a national policy on AIDS as it affects corrections. Each of the jurisdictions, of which there are 55 state jurisdictions and territories and more or less 3,400 county jurisdictions, and of course the Federal jurisdiction all have a correctional program. They are always doing the same thing, so we have a variety of programs in the United States. Mr. Chairman, in trying to bring together the same questions that Mr. Hansen and perhaps you have espoused this morning before I arrived but many of the questions we have don't seem to fit a mold of what perhaps might be within the public interest because of the kind of population we have.

And we speak—this morning for the entire criminal justice system as we look also at the police officer's responsibility and the judge's responsibility.

Should the judges put all prostitutes in prisons who have AIDS? We don't think so, but that is a legitimate question that some people have asked, if they have had another felony charge. Should they give longer sentences to defendants who have AIDS? Should pre-sentence reports require an AIDS testing procedure before it goes to the court?

Then we get into probation. Should probation officers maintain the screening system and should the results be confidential? We are really struggling with this confidentiality. As late as Tuesday of this week, I was in Minnesota and the question, is not a correctional officer entitled to know when an inmate has AIDS was brought up. There is no answer to that question at this moment. There is no policy development. Many states have laws regarding confidentiality and others don't, so we have a mixed bag on that.

This morning in College Park, MD, we are having a meeting, to discuss that question, and several of the jurisdictions at that meeting tell correctional officers that an inmate has AIDS. We find out that through the grapevine that whether you tell them or not, the news is public and the grapevine is a very significant method of communications. It works whether you think you are passing out

confidential information or not, so it seems that everybody seems to know who has AIDS whether it is a correctional officer or an inmate.

Now, the question you asked Mr. Hansen this morning about separation. There is only one state in the Union that is beginning to separate sero positives and that is California. We are not sure how that is going to work once they get into the large numbers. But basically there is no policy, however, most correctional people feel you should not separate sero positives from the general correctional population. They should stay in general populations.

If we get into the segregation concept and if we get into separate institutions, we don't know that there is enough money around to help. We have a difficult time right at the moment trying to get money to support a correctional system, but if we must have a second correctional system developed for AIDS patients, we are talking about considerable dollars, Mr. Chairman, which of course includes the Federal Government.

We are asking in our testimony this morning that Congress, as they look at medicaid law, allow the state through legislation to have inmates subject to medicaid payments for the cost of AIDS. The cost is now being borne by the correctional departments, and generally speaking, there isn't enough money to pay for this and it is always a deficit appropriation for the state or county, and the numbers are quite significant when we get into an active AIDS case where a patient needs hospitalization.

So these questions, Mr. Chairman, are as significant as the ones that were made this morning by Mr. Hansen. We would like to know, in the future should we hire a different kind of person working in an AIDS environment. We are doing training, massive training, and we still have a difficult time training people who have general understanding of what AIDS may be but not an intimate understanding of it.

Again, as late as this morning of our meeting we talked about the number of hours that we currently have in AIDS training. Generally it is just a two-hour training program. Should it be an ongoing weekly program? Should we increase the number of hours?

We know that public health officials do more training than we do in corrections but the resources are not available for corrections to do the massive kinds of training that we think is necessary.

We also have the parole boards, Mr. Chairman, and there we have some real serious questions. The Federal Parole Commission is asking through the Federal Register several significant questions to be answered or at least give some guidance on and and again what—is it their responsibility to tell everybody whether someone is released from a prison on parole with active antibodies or who has AIDS. Should they tell the public health community? Should they tell the family or should they allow the inmate to tell the family or the parolee to tell the family? What is the public responsibility to the public in this whole area?

Currently the thinking is that we follow the good social work practice that we allow the inmate to do the telling. But then again we say, how much time should he be given to do the telling? Should we allow him a week or two weeks or—and then we tell? We don't know. It is a moot point right at the moment, Mr. Chair-

man, and we are not sure and again, should, as I said, should public health facilities be told?

We are seeming to want to handle this as a communicable disease and tell various people that have a need to know. This is still subject at the moment to nationwide—as I say, policy setting so we are in a quandary and we would like to think that the public health community is going to be continuously helpful to us to meet the challenges but we think in a correctional environment we have unusual problems of which overcrowding is a severe one and mitigating against some of the good practices that Mr. Hansen recommends that we adopt.

We would like to adopt all of those as we ordinarily should but sometimes resources aren't there.

[The statement of Mr. Travisono appears on p. 90.]

Mr. RANGEL. Well, law enforcement traditionally has not been involved in political activity except in terms of collective bargaining but if you are concerned about some of the things that Mr. Hansen has talked about, I just wonder whether your association would be the proper one to deal with it.

One of the things that struck me is the idea of alternative sentencing where people that have not committed violent crimes should be thrown into the general population. It struck me that there is hardly anyone who believes that rehabilitation is the part of the prison system, that it is generally perceived in society that one leaves as a better criminal than as a better citizen. I am not saying that these things are true.

The question of homosexuality, homosexual activities in prisons. Some people believe that some of the people are assigned based on sexual preference and that these things are done with the consent of the authorities. Others are concerned about rumors that rapes take place, that young inmates are subjected to these brutal things which, in this particular case, could be a sentence for murder.

I know these are unpleasant subjects. I know they are so unpleasant that even the chaplains that are assigned to the prisons don't talk about them, and I also know the difficulty it is for corrections officers to have had that in order to bury these social problems they put the prisons away from the taxpayers in rural areas more often than not——

Mr. TRAVISONO. Who does this?

Mr. RANGEL. The politicians do it.

Mr. TRAVISONO. That is right.

Mr. RANGEL. The politicians do it, so I am saying I know what you have to overcome but still if you expect to be helped, I would hope that your association would get together and instead of raising the questions of the problems that you are facing as professionals, start asking some of the elected officials to come up with some of the answers. I am afraid that we are going to have to respond because this is a very expensive proposition and a stupid proposition to invest that type of money to keep someone incarcerated when there are alternatives that could really make a better person and better protect society, and I might add, make your membership feel that they are making a positive contribution toward society where they can feel proud of the fact that they have made a contribution to an inmate learning something, as opposed to what has to

being one of the most thankless jobs in the world and just having three shifts to keep someone warehoused in a prison.

Mr. TRAVISONO. Well, Mr. Chairman, I appreciate all those remarks and our association does work in that direction; however, I would like to go on record as saying that we consistently feel that we are the new community dumping ground for all people with problems, whether they are problems of minor crime or major crime, and that that separation that used to be a little more defined in the 1970s has lost a little impetus in the 1980s, and we are getting everybody now even though the role of probation has increased significantly so we still have approximately 75 percent of the people adjudicated guilty on felony convictions who are on probation or parole with only 25 within the institutions so both caseloads have been consistently rising over the past several years.

It is more demonstrated of course in the institution where the numbers of crowding are up to 160 percent of capacity, so we are trying desperately to continue to help judges and communities and politicians with a whole series of policy statements saying that prison is not the only answer. It is an answer, but not the only one, and parole and probation are still significant and we feel politicians listen but they also listen to their constituents and they talk louder than we do.

Mr. RANGEL. That is the point. You have to consider yourself a constituent and it is difficult because the directors are appointed. They take some political risks, but what you are talking about just makes good sense, even dollars and cents, and if you know that the social scientists support what you are talking about, then it is going to take a little courage for you to come together and to say that you are not only the keepers of human beings but also you are citizens and there has to be a better way to do it.

Now, for years police officers and police chiefs never got involved in the policy questions of whether there is an active strategy. They didn't get involved. They, more than any other group, are responsible for the passage of the 1986 Omnibus Drug Act because they put their credibility on the line; they are respected as law enforcers and so they are involved in education and prevention and even getting at the source, because they know that they can't deal with the problem alone and just expect to arrest people and put them in jail.

I hope that you would allow me and others to work with your association so that you will be able to say that while you may be able to put in your 20 years and get your pension, that you can't walk away from that job thinking you made a positive contribution if the only thing you are doing is turning the key on the lock, and I know this is what you would want to do. I know that you can't just jump out there politically and do it, but if you work with us, I think there is a way to do it without jeopardizing the welfare of your membership.

Mr. TRAVISONO. Mr. Chairman, we are well aware of your long-term interests and what you have done over the years. We welcome your involvement.

We would like to have many of your colleagues involved with us on this issue and we hope you will help us do it as we approach doing what you suggested. Thank you very much for that.

Mr. RANGEL. Thank you very much for coming here, and this is another thing that the President's commission probably will have to have in its report, not because you want to and not because I do, but it just has to be mentioned and we will have to tackle it.

Thank you so much.

Dr. Lorraine Hale, and her mother, who I hope will come up here and sit with her, are real national symbols now. But in the Harlem community, they have had the courage to reach out and open up Hale House, which is an official extension of what Mother Hale has done over the years. As a matter of fact, it has been rumored that Dr. Lorraine Hale had so many brothers and sisters that she didn't know where they came from. And, the amazing thing, Dr. Lee, is how almost all of these kids that have been left with ability achieve education and higher education to bring back a sense of pride not only to Dr. Hale, but certainly to the Harlem community.

We were pleased to see that President Reagan took the time during the recent State of the Union Address to point to Dr. Hale and her daughter, who was sitting in the Visitors' Galleries so that their work would be known nationally and internationally. We are working hard in the Congress to get the funds to keep up with the President's proposal to support this type of volunteer effort.

Thank you so much, Dr. Hale, for being with us. We welcome your testimony and your full statement will appear in the record.

TESTIMONY OF DR. LORRAINE HALE, EXECUTIVE DIRECTOR, HALE HOUSE

Ms. HALE. Thank you so much, Congressman Rangel. I would like to thank you for throughout, it seems to me, the confusion of events surrounding the outbreak of AIDS, your leadership has always been present. Both mother and I are pleased that you kept your focus on the issues of drug abuse as a primary cause of this social, medical, moral and economic disintegration of our community.

Today, as a result of your wisdom, we are gathered here in the halls of Congress to discuss AIDS, for many other dimensions of drug abuse and to make recommendations for solutions. For this we owe you a very large debt.

Dr. Heagarty is no longer here, but I want to publicly thank her. She is a chief of pediatrics at Harlem Hospital in New York City. Certainly no one I know is as close on a daily basis to the children we are talking about here today, those babies with AIDS.

When AIDS first came to Hale House two and a half years ago, we were frightened and we called Dr. Heagarty because she had the babies. She sent Dr. Nicholas to Hale House to meet with us and he explained how the virus was transmitted. Our fears were diminished considerably.

Since then we have had other babies with the antibodies who were also admitted into Harlem Hospital. We have had seven to date, four of whom have died. Today, Hale House is much more sophisticated and we don't get frightened anymore. We are fearful, tentative, we take care of ourselves, but we do know that probably within our population we do have children with the virus.

Our appreciation also go the other panel members because I know each of you has recognized that, though the number of infants with AIDS may be small today, the potential is great. We know that in the African-American community, the majority transmission category, 52 percent of the some 1,878 women who have AIDS is caused by intravenous drug use while the second largest category, 21 percent, is heterosexual contact with an infectious person.

It is this latter statistic that should come as no surprise when we know that between the ages of 20 and 24 there are only 54 black males to every 100 black females. I give that information because it is very important in light of the kinds of statistics that are being discussed here. This information that I had can be found in a 1982 study by William Wilson and Catherine Beckman, University of Chicago. It is called "Trends in Employment and Family Patterns, Poverty and Family Structure, the Widening Gap Evidence and Public Policy Issue." The major poll in connection of males unemployed, incarcerated indicated also that between the ages of 25 and 34 there were only 59 black single males. There were only 47, I'm sorry. There were only 47 black single males to every 100 black single females. Given this statistic and the exploratory nature of men, the sexual needs of women, unless extraordinary educational steps are taken to inform young adults regarding precautionary measures, the virus will continue to spread.

The great concern that many of us share is that the disease not be seen as a black disease or Hispanic disease or a gay disease, yet it is increasingly being seen in terms of race and ethnicity. The expected cross-over in the middle class has not occurred.

An article by Robert Chear appeared in the Los Angeles Times on August 15, 1987, entitled "AIDS Consensus, Heterosexual Threat Exaggerated," and it could be interpreted as a beginning of the pattern of which I am very concerned. Here are some quotes from his article. "AIDS among the heterosexual population is not spreading at the anticipated rate. It continues to spread among intravenous drug users and homosexuals. As a consequence, there is a growing consensus among leading medical scientists that the threat of AIDS to a wider population, while serious, has been exaggerated.

"According to the Center for Disease Control, more careful study of widening publicized instances of heterosexual transmission can be found—was found to be unreliable. CDC studies show also that in areas such as California and New York where AIDS is epidemic among homosexuals and drug users, very little cross-over to the mainstream heterosexual population has occurred. Dr. Robert Gallo, National Cancer Institute researcher who was a discoverer of the AIDS virus, said, 'Our danger by far in this country is the drug addiction. But if the drug addict problem doesn't get any worse, I doubt whether heterosexuals at large are going to be anywhere near the problem that it is in the homosexual population.'"

Everybody has his own agenda and the thing that fuels the resources for AIDS is the threat of heterosexual transmission. The people who are spending the money basically don't care if a bunch of gays—gay men and drug abusers get AIDS. They really don't care.

Unfortunately, the AIDS virus is spreading among the non-drug-using population within the African-American community. According to Dr. Gallo, in the future we will see a widespread—the wide spreading of this virus among only that population. Certainly I think you will agree there are few of us from the African-American communities who are in the mainstream of American life. We are under-represented.

The great concern that we had in the 1950s and we shared it was that we had a drug problem and it was ignored. It peaked in the 1970s at 500,000 and to the best information that I can obtain, it is still around 500,000. That is of heroin users. However, the consequences of this—these 500,000 users could have enormous effect upon our community. But again the problem is that it not be seen as a black or Hispanic or a gay problem but as an American problem.

I happened to come across an article in the New Republic by a Charles Kreitheimer. It was in the October 5th issue, in which he says, "AIDS is a serious problem. The amount of concern about it is—and the talk is almost embarrassing and the hype is amplified by the media. It originates with political leaders who ought to know better. But they are indicating that it is such a serious problem, if you will. In fact, the Chairman of the House Subcommittee on Health and Environment, Representative Henry Waxman called AIDS the most serious epidemic we have ever faced." According to Mr. Kreitheimer, that is nonsense. In fact, in three years a black plague killed one out of every three Europeans. The flue epidemic in 1918 killed 22 million people, more than died on all sides in World War II, civilians included, and in America alone, half million died of flue 20 times more than have died of AIDS in this decade."

Those are very important—that is a very important statement that he has made because what he is saying in fact is that it is not very important because it is limited to just a small group of people, minorities. He goes on to say that—and I thought that this was really very important. The only people who are victims in effect are babies and some hemophiliacs. The other people, particularly the gays, are people—and I want to get this right because I thought it was a very important statement.

How much information can you give people about AIDS? For AIDS, the problem is not so much ignorance as it is will. How many gays are there who do not know how AIDS is transmitted? How many addicts are there who do not know they should not use contaminated needles?

In this respect, AIDS resembles lung cancer or older epidemics. With the rarest exceptions, those who are carrying the infection today as opposed to those who contracted AIDS before the cause was known are those who decided to take the risk thinking that the roulette wheel will not stop at their number, and I think that that is—those are important statements because it leads to just the kinds of things that we want to avoid.

I would like to avoid people thinking that those folks that are getting AIDS are getting it simply because they don't want to practice safe sex, that they don't want to do those things that are necessary to protect themselves. It is almost as if each time I hear

someone say, well, let's put all drug addicts, people who are using drugs, on methadone maintenance programs," and I didn't know that methadone was a cure for AIDS, and I keep asking, is it. Well, how is putting people in methadone maintenance programs going to stop the threat of AIDS? They probably already have it and going to those programs will not prevent them from having it and perhaps spreading it, and I am not going to say too much more about it because Dr. Brown is sitting beside me and he is from a methadone maintenance clinic and he is my friend, and I don't want him to stop talking to me, but there are those who agree there are innocent victims of the disease and it is babies. The absolute, the only, says one article, innocent victim of a disease, victim of both the habit which becomes a disease and the disease which kills, this victim is the newly born.

This leads me to acknowledge the inspiration for forging ahead with the concept of the Hale House cradles. In the past April in Philadelphia, at the Children's Hospital I attended the Surgeon General's conference on AIDS. I recall the quote from the report, "There is much we do not understand about this disease, but we do have enough knowledge to treat these children so that the quality of their lives is improved. It is our responsibility to ensure that they receive the medical and social care they need to live humane and civilized lives. It is our moral obligation to do so."

On the day following the end of that Philadelphia workshop, our staff spent endless hours discussing, arguing and revising our program for pediatric AIDS. I was adamant about only two things, that we move expeditiously and we—and to ensure our input to help these children and that they operate in conjunction with the pediatric department of Harlem Hospital. We have moved to recreate a program similar to the current Hale House, hence the cradles will be a small group home or residence for unrelated babies born addicted to drugs but in addition these babies will have also positive antibodies for AIDS.

For many years people have spoken of Hale House as the model of infant care in group settings where parents get a fair deal and where they are always represented. Yes, Hale House is a model but more than that, it represents the ability of ordinary Americans, black Americans, if you will, to identify a community need and to organize the resources necessary to address that need and to make changes.

Today we have the same faith and courage we had 19 years ago. People ask if we are afraid of our new commitment to those ill infants. Our answer is no. Faith and fear cannot coexist. Pediatric AIDS is simply, is in simple talk means a sick baby. That is all it is. Our mandate at Hale House is to care for babies who are well or sick.

I talked here about things that we will do, but one—I would like to leave, Congressman, with the thought, returning to earlier remarks, I remind those listening to remember two historical facts. The first, drug use and abuse in the African-American communities. Drug use and abuse, though known and documented to be an American disease since the 1800s—it has been documented—was in the 1950s deliberately and systematically brought into the black communities. Media focused on black addicts as a problem. As

such, it was ignored and allowed to flourish—to flourish, destroying two generations of African-American youth, but as with all diseases, it spread evidently touching the lives of almost all Americans.

Second, the Tuskegee study. The Governor of New York state recently mandated AIDS testing for persons in high-risk groups. That means people who are IV drug users or homosexuals.

This testing is to be done without any plan of disclosure of the findings to the affected person or those who are not infected. There is no disclosure plan involved.

I ask you to remember the Tuskegee study because that is exactly what was done in Tuskegee back in the 1930's, where people were tested for syphilis, and not told whether or not they had it and the disease was permitted to run its course, and in running as scientists observed.

Here again, I find that researchers are rubbing their hands in glee at a new researchable animal, black men, black women, black children with AIDS. I ask you to please remember the history. Stop the disease in Harlem among the IV drug users, so that all Americans everywhere can live tomorrow.

The wisdom in this room today I feel certain will make the right recommendations, and further than that, I feel very certain the right legislation, if legislation is required.

There are times in history when the right thing must be done because it is the right thing to do. I believe and my mother believes that this is one of those times. for remember, those who forget the past are destined to relive it.

Thank you, very much.

Mr. RANGEL. Thank you, Dr. Hale.

And now to wrap this conference up will be Dr. Lawrence Brown, Director of Research and Medical Affairs for the Addiction Research Corporation. Dr. Brown, your full statement will appear in the record.

When Travisono was talking about the prisons being the dumping ground for social rejects, I couldn't help but think the tremendous responsibility that rehabilitation clinics have for drug addicts. You have the professional responsibility to allow people to believe that you are actually rehabilitating people, including Dr. Schuster who is very proud of the methadone maintenance program. Yet, it has been my experience that they give you nothing to work with as patients, nothing to change the economic or social life, and they tell you to present someone who is going to make a contribution to society. And, they ask you, as I often times do, just what are your success rates. I know that offends most of your professional group, but it seems to me that sometimes rehabilitation means to those of us who are not professionally involved that you reduce the addict's habit, and he can get back on the streets in better shape than he was before he met with you. That is a very biased and untrained view, and I hope that you correct me as we anxiously await your presentation, Dr. Brown.

TESTIMONY OF DR. LAWRENCE BROWN

Dr. BROWN. Thank you, Congressman Rangel. I so wanted to tell my colleague, Dr. Hale, that while she and I may differ on a couple of points, we are still in the struggle together, so that I have grown to respect the fantastic work by her, and her mother. In fact, I have had some personal interaction with a number of the youth that she has had in her program, so I know the fine job that she does.

Mr. Chairman, I want to thank and offer my sincerest gratitude for the opportunity to discuss with you and the other members of the Select Committee on Narcotics Abuse and Control a phenomenon that greatly threatens the very fabric of the black community. As you know, I serve as the Vice President for Research and Medical Affairs of the Addiction Research and Treatment Corporation (ARTC), an organization that has prided itself in serving the hardcore, lower socioeconomic, and predominately black and Hispanic addicted since 1969. As a not-for-profit, minority operated organization, ARTC has provided a wide range of comprehensive health care and treatment services to well over 20,000 patients since its founding. The AIDS epidemic has astounding effects on the health care and the social well-being of the patients, the recruitment and efficacy of treatment staff and the resources in the urban centers in which these facilities reside and in which drug abuse promulgates.

My charge in the communication that I received was to comment a little bit about the AIDS epidemic and its impact on drug treatment. Given that intravenous drug use represents the second largest transmission category for the development of AIDS, it is not surprising that intravenous drug users would also develop a greater prevalence of AIDS-related disorders. In many cases this has resulted in further stigmatization by the general public, traditional social service agencies, some hospitals, and even some drug treatment programs. I have personally had complaints from some patients who claim that certain residential programs, therapeutic communities, require them to be tested for the HIV or AIDS virus and once they test positive they are denied admission. At a time when drug treatment represents a potential modality to remove these people from the pool of infectivity, those behavior patterns that expose them to the HIV virus, this represents a true atrocity. That drug treatment enrollment truly represents this potential has been demonstrated in a collaborative study between ARTC and the Addiction Research Center/National Institute on Drug Abuse. For that, I must say parenthetically that I and Dr. Prim have looked firmly upon the support that we have received from Dr. Schuster. It has become very good and productive assocation.

With regard to that collaborative study of the nearly 500 patients who participated and received extensive pre-test and post-test counseling, those persons who tested positive for the virus had a statistically significant shorter enrollment in our program than those who tested negative. While drug treatment should not be looked at necessarily as the end all in the process of rehabilitation, we do need, Mr. Chairman, any mechanism and all that would reduce the pool of infectivity, and thus somehow break the progression of

transmission from person to person. While this finding may be suggestive of a positive role of treatment, one can not conclude that by just opening more positions, our problems with AIDS are resolved. In the AIDS epidemic era, quality is equally important. For an example of this, one need but look to New York and the response of its single state agency. While this agency aggressively encouraged treatment programs within the state to expand, it did little to provide a proportionate number or amount of resources for the wide array of medical and psycho-social problems associated with the HIV-infected intravenous drug abuser. The problems of the drug addicted suffering from AIDS or a related disorder is many times those of the non-infected. It has always amazed me, a health practitioner, why our health care system is not receptive to improve the level of primary medical care offered in many of these drug treatment programs, at least as a means of early recognition of HIV-related consequences (and hopefully early intervention), but is very willing to invest in expensive tertiary care instruments, that are either not available for this population or of little utility by the time drug abusers present themselves for hospitalization. Let me make it abundantly clear. I am not against highly technological health care. Quite the contrary, I so happen this month to be the attending physician on one of the medical wards of Harlem Hospital this month, I complain bitterly about the limited availability of intensive care unit beds, resulting in the management of patients requiring respiratory support on understaffed general medical wards. One third of my thirty-five patients under my responsibility on my ward are hospitalized due to AIDS-related disorders and nearly all of those with AIDS related illnesses have histories of intravenous drug use. Yet, again this appears to be the legacy of the treatment of the addicted.

Unlike the largest transmission group of homosexual/bisexual men, intravenous drug users tend to disproportionately reside in the lower rungs of the socioeconomic ladder, tend to be geographically stable, and do not have any vocal lobby in Congress, or for that matter, anywhere in society, that aggressively articulates their concerns. Thus, other than drug treatment programs, there are few places, off the streets of our inner cities, where drug abusers are welcomed. While many of the AIDS related disorders, such as ARC or AIDS-related complex often received lesser levels of attention in the lay press, the recent August 14, 1987 revision of the surveillance definition of AIDS by the Centers for Disease Control, may result in a re-classification of the previous ARC cases to AIDS. The result may be a significant rise in AIDS cases, largely due to the definition revision artifact. While this revision will allow a greater number of the HIV-infected to receive a greater level of social services, because they now meet the CDC surveilance definition of AIDS, it also offers the potential for a greater number of drug abusers to be stigmatized.

From the standpoint of the treatment programs, there are monumental needs that woefully require satisfaction. Many programs are understaffed and unaware of the limited resources available to meet the social, economic, and legal needs of the AIDS patient. Recruitment of qualified medical and social service staff is difficult and retention of qualified staff is equally formidable, given the

high level of stress associated with the care of the HIV infected. Anxiety levels of the staff in many programs are extremely high, often resulting in unconscious stigmatization.

For the communities in which drug abuse is prevalent, the toll is even more devastating, particularly in New York. Approximately 34 percent of the total reported cases, 44 percent of pediatric cases, and 51 percent of adult female cases of AIDS reside in New York state, principally in New York City. The case fatality rate in New York of 57 percent is also in excess of the national average. This disproportionately greater risk experienced by New York is largely believed to be attributed to its large community of substance abusers. Indeed, more than 850,000 persons or a most of 6 percent of the state's population are heavy substance abusers with 58,000 of these estimated to be intravenous drug users, which represents nearly 65 percent of the estimated 400,000 nationwide intravenous drug abusers. This apparent similarity in the distribution of AIDS and substance abuse stimulates a myriad of questions.

The significance of intravenous drug abuse in the prevalence of AIDS and AIDS-related disorders is particularly devastating among blacks and Hispanics. Between whites and minority group members, the racial distribution by risk behavior differs. AIDS cases that could be traced to homosexual or bisexual men or to the use of blood or blood products were more likely to be white. Blacks and Hispanics dominated in cases associated with heterosexual contacts, with no identifiable mode of transmission or IV drug abuse. In fact as Bakeman and his colleagues at Atlanta University and Morehouse School of Medicine point out in the September issue of the Journal of the National Medical Association, the best predictor of AIDS among black women is the distribution of male heterosexual IVDA cases. There are clearly other issues for the communities in which intravenous drug use is rampant. For one, AIDS and intravenous drug use strikes during a highly productive period of life. This has to offer a serious handicap in the economic base of these communities. While epidemiologic evidence has not shown that HIV infection can be casually acquired, one HIV-related disorder, tuberculosis, is rising rapidly in inner city areas where drug use and AIDS are prevalent. This is truly a direct public health threat to these communities. Finally, in communities where social services and sources of health were already plagued by issues of inadequate quality and inaccessibility, a new demand offered by what was traditionally a low health care utilization age group further exhausts the health care resources in these communities.

Given this litany of problems, let me offer a few ingredients that may be useful in a rational response. First, let me say that drug abusers are capable of change. Based on a number of surveys, many have received the message. A very large number claim that they no longer share needles and a surprising proportion claim to even use some form of liquid to clean their needles prior to use. Thus, we sorely need more messengers and more messages. The messages should be well founded in scientific and epidemiologic phenomenon related to HIV exposure or progression and should be culturally-sensitive. As for the messengers, television, newspapers and pamphlets are insufficient vehicles of communication for the drug addicted. There is a need for a cadre of foot soldiers much like

the organization called ADAPT in New York City to get out and deliver the word. For drug treatment programs to attract and retain individuals in treatment, there is a considerable need for an improvement in the quality of services. When one compares the exteriors of drug treatment programs in many urban settings with that of other types of health care facilities, it is no wonder why drug abusers are not encouraged to attend. Finally, the quality of primary medical services must be enhanced in drug treatment programs if we are serious about impeding the progression of HIV related consequences or about early intervention prior to greater morbidity and mortality to the drug user or, as in the case of tuberculosis, to the communities in which intravenous drug use is abundant.

Again, Mr. Chairman I thank you for having provided me with the opportunity to share with you some of the thoughts and concerns of my colleagues and staff about their ability to respond to this devastating epidemic and most importantly, about the significantly unmet needs of the drug addicted and our communities.

[The prepared statement of Dr. Brown appears on p. 103.]

Mr. RANGEL. Thank you, Dr. Brown, for you very thoughtful questions. Before we get to questions, could you very briefly tell me what is the profile, what would you call the people you are treating, clients, patients or both?

Dr. BROWN. I must confess, Congressman, that because I am trained as a physician, I often stumble on patients.

Mr. RANGEL. What would be the profile of your patient? High-school dropout, criminally active, on some type of public assistance?

Dr. BROWN. I think the profile does differ to the extent as to how they are involved in treatment. Very often upon coming into treatment, there is a greater extent of criminal activity, usually after being in treatment, I would say from six months to greater there is a lesser level of criminal activities. In fact, there have been very extensive and elaborate studies to that effect.

Mr. RANGEL. I never thought that they would be actively engaged in criminal activity while they were your patients, but before you get—especially the heroin addict, does he normally come in with a couple of convictions, with health problems, without a job, or unemployed or unemployable?

Dr. BROWN. Most definitely, from what we see in the inner cities, the profile is one of unemployment or under-employment. The profile is one of an extensive area of medical problems based on their history or what they currently present.

Mr. RANGEL. See, Dr. Lee, I ask these questions because we have these rehabilitation centers and methadone clinics, and they write the reports, and God knows what life would be without them, but it is clear to me that what they pick up in the limited time that they are exposed to the good doctor and his staff, that when they return to the community, it is not going to be drug free for long, or they don't have the resources to make themselves a productive citizen.

Assuming that they are drug fee or methadone maintained, if you brought them to me and ask what am I going to do with that person, there is very little that we can do.

I don't mean to say anything that would offend you professionally, but to me it is a holding action any more than the prison system is a holding action. That is why I want Dr. Lee to know that he can depend on my entire support in bringing the facts to the President's commission, because it is going to be what cause people, at least in this part of the project, to become dependent on drugs. What is it that causes them to inject this poison in their veins? What are they trying to run away from? And whenever one says that we are going to have to educate people in a different way, then what they are admitting is that this person is not a part of the American way of life, that, just say no, that we watch on television, or getting a little red book. That we are now talking about time bomb that exists in our communities. There have been suggestions from the panel that we are going to have to find people that know how to communicate with these people, in order to get them to contain this damn epidemic and not spread it.

This would be the first time, Dr. Lee, that people are recognizing that this population exists, with or without AIDS, and even for this prison population, there is not a vote among them. Who cares? You arrest them, you campaign on the fact that you have had these arrests and convictions. You find out what a rural town needs is some economic development. You run a bond issue, you build a prison, and that takes care of it.

Now AIDS is going to bring the George Hansens and other people, and these people who are often times underpaid and under trained who are scared to get this—that they are going to get AIDS. They are now going to start talking about prison reform.

I think that your commission could really be the most educational thing that I have seen happen in the last two decades, Dr. Lee.

Dr. LEE. This is the thing that I have definitely come in on, all of these peripheral problems related to AIDS to me have largely been solved or are being solved by experts, things like testing, et cetera. The research is going so well. I am amazed at the amount of stuff that is going on in the NIH. The kinds of things we are talking about today, you are right, it is too late.

I mean methadone maintenance, these are foot soldiers who are doing a fantastic job, but it is too late. We have to do something about shoring this thing up right from the bottom.

I have in my document that I submitted something I was going to read. It was about a principal. I went to a graduation at a grade school in Harlem called the Mahalia Jackson Elementary School, and the principal is a woman called, Mrs. Constance Wingate, and right up on the stage in letters four feet high was, "No, no, no", and in this graduation it was no to sex, no to drugs, learn to say no, and this woman got up, and these kids hung on her every word.

She said, "I am here. You are my kids. You go out there and you represent me, and don't you ever forget it." Those are the people that are making the difference. Somehow we have to foster that kind of behavior. It is an unpopular subject, but it is going to cost some money.

Mr. RANGEL. Dr. Lee, you know that it is going to save some money.

Dr. LEE. That is correct.

Mr. RANGEL. I ask the Executive Director of the Corrections System what would you say roughly is the average taxpayer's cost of incarcerating a prisoner annually?

Mr. TRAVISONO. The correctional cost is in the neighborhood of $16,000 to $20,000 per year. That is just the cost of incarceration. The social cost, Mr. Chairman, is incalcuable. We really don't know what it is. The family goes on welfare.

Mr. RANGEL. The prisons, the judges, the probation officers.

Mr. HANSEN. Mr. Chairman, may I inject, a lot of these people, particularly where I am, are people who have a capacity for making a good amount of money, besides that we got them there. There is a lot of lost tax revenue. You are on that committee. Your are talking about people who would probably pay much more taxes than it is costing to house them down there. You are talking about $50,000 a piece that it is costing the government to have these people locked up.

Mr. RANGEL. The problem, Dr. Lee, is that as a professional politician and I know talking about prisoners is not going to get you one vote. Unfortunately, talking about putting people in jail will get you votes. You can't pass a bond for decent housing, but you can pass a bond in the middle of the night for a larger prison. So I know it may sound like I am picking on you, but the prestige of your committee just reporting these things for a lot of people will be truly enlightening to see what we are prepared to invest in that is costly.

Another thing, the President has talked a great deal about National Security. I would not know how to point out the fact that in the black community and Hispanic community we have done more than our share of fighting the wars. Even though the nation would be hard put to find us heavily involved in communism, I refuse to accept, as a Purple Heart veteran and Bronze Star medal, that blacks are more patriotic than whites. What has happened is that we have looked at the military as one way of getting out of that inner city and getting a job, as an economic development too. And it works in with national policies. If you take a look at who died in Vietnam, who died disproportionately in Korea, that would be blacks and Hispanics.

Even for that security, is Dr. Brown preparing a list of volunteers for our military leaving his centers? They are not prepared to do anything to protect our country. As a matter of fact, a large number of blacks, if you are in jail, if you are on drugs, if you have AIDS, when it comes time to even be drafted, are not eligible for national defense or security, and certainly the effect of this has been more devastating than what any communities have ever done to our country and to our young people.

And so from every aspect as we look at this drug problem, I would ask Dr. Schuster, who is really a professional—professional as it relates to dealing with this problem, do you feel satisfied that we have a national strategy outlined, that is part of and is dealing with this crisis that our nation faces?

Dr. SCHUSTER. Well, I can only say that in the past year there have been, as you know, the establishment of a drug policy board. Attorney General Meese was the Chairman of that, and Secretary Bowen the vice-chairman. This represents a very important devel-

opment, because no longer do we simply have a drug enforcement policy board which deals exclusively with interdiction and criminal aspects and supply side production aspects, but rather we have healthy people and the Criminal Justice System sitting down and talking about a national policy.

We are in the process right now, for example, of working with all of the agencies in the Federal Government that are involved in drug abuse treatment, as well as those others who are involved in services that relate to treatment, such as Social Services Administration and others. We are going to have on the desk of the Drug Policy Board by the end of October a report on what we feel should be the national strategy in terms of how treatment capacity should be increased, in order to handle the current problem of AIDS, as well as, cocaine.

All I can say to you is that this is being done in addition to other policy statements being made by groups having to do with prevention, having to do with the effect of drugs in the work place, as well as my particular charge, which has been with the hard-core drug addict, and we are preparing that report right now.

Mr. RANGEL. Let's have a qualifier so Dr. Lee will know I am not being political about this here. I assume the Attorney General is in charge of this policy board?

Dr. SCHUSTER. He is the Chairman of the Drug Policy Board, yes.

Mr. RANGEL. This is the same Attorney General that opposed any assistance for local and state law enforcement, right?

Dr. SCHUSTER. I am sorry, I am not as aware of many of his activities as you are.

Mr. RANGEL. You take my word for it. That is the case. Now in this national strategy, everyone has been talking about education and prevention. We put some $200 million in the budget in 1986 for this purpose. The Administration has cut that back to $100 million, and in addition to that, Dr. Bennett has indicated that he doesn't believe that we should be involved in education on the local level.

As a matter of fact, he believes we should do two things. Just say no, and I believe he stole that from somebody of national prominence, and two, to have zero tolerance, that meaning if you find someone abusing drugs in the school system, kick them out. In front of this committee, when we asked what happens in order to prevent it, he said that is local and state. When we said if you are unsuccessful, what happens to the kid that you kicked out, he said that is local and state. I am just trying to help Dr. Lee in seeing the problem that we have in not being political.

You talked about Ed Koch's idea. Well, that may sound a little bizarre, but I think most people believe that we have to go to the source. We have to talk with these countries that are producing hundreds of tons of drugs, that are receiving military, economic and technical assistance. It just means that we will go to the source and do something.

I challenge your commission to find any statement that has been made publicly by Secretary of State, Shultz. This is not to say that we don't have copies of two speeches that he made, and this is not to say that he hasn't spoken with his State Department people. And the same applies to Secretary of Defense, Caspar Weinberger, in saying that we are going to invade Grenada, we are going to

support the contras, we are going to go to the Persian Gulf. We have got to do all of these things that concern our national security, but if you think you are going to bring drugs into these United States, we want you to know that DOD is watching you.

You find that statement, put it on paper, I will eat it. I am not going to get political, because we are in this together, but you show me the strategy and I am prepared to support it.

Are there questions from those in the audience to me or any member of the panel? Will you identify yourself. There is a mike in the back.

VOICE. This is for Dr. Schuster. If you could please outline for me again the problems and solutions involved in prevention, intervention, and the heterosexual spread an IV drug user to a non-drug using partner?

Dr. SCHUSTER. First of all, as Mr. Rangel has stated, we have a very serious question among these drug abusers because of lack of education, because of lack of marketable job skills, because very frequently the issue of other existing psychopathology. We haven't talked about it here, but I want to point out that many heroin addicts not only are heroin addicts, but as well suffer from major depression and other forms of mental disorders.

We can't speculate that those kinds of people are going to be as sensitive to drug education messages or health behavior messages as well educated people who are very conscious of their health.

It also has been stated the issue is that these people have less to live for. They are already risking a great deal whenever they are put on an intravenous drug because they have no idea what the qualities or purity of it is, so getting a health message across to them is very difficult.

Our intent, however, is to attempt to get to these people early. The younger you can get to people in their drug involvement the better chance you have to not only get them to stop, to decrease their drug taking, but as well to have full scale rehabilitation, because it is still possible for them to get an education, for them to get job training and so forth.

Right now we are working on this treatment subcommittee that I previously talked about, attempting to get demonstration grants that involve not only drug treatment but as well the Department of Labor in terms of job training, in the Department of Education in terms of adult literacy training. Those kinds of things can give rise to full scale rehabilitation, and also at the same time would clearly make these people much more sensitive and much more sensible about general health care, including the problem of AIDS.

VOICE. Just a follow-up. What do you say specifically now to the IV drug user and his non-drug using heterosexual partner? How do you address them with education and information?

Dr. SCHUSTER. The messages are simple. The first thing is get into treatment and stop taking drugs. The second one is if we can't get people into treatment, if they are unwilling to come in, then we have to tell them about how the AIDS virus is spread through needle sharing, we tell them that the virus can easily be killed with household bleach, or for that matter, vodka, whiskey, or gin, any fortified alcoholic beverage. They have to have that information.

Their sexual partners also have to be aware that if they are intravenous drug abusers, they shouldn't wait to get an AIDS test to find out whether they are positive. They should be practicing safe sexual practices, no question about it.

Mr. RANGEL. Has NIDA taken a position on the distribution of sterile needles?

Dr. SCHUSTER. The issue of sterile needles is one that we have had two technical reviews on. We have reviewed the evidence from Amsterdam and various other places in the world where needle exchange programs have been initiated. It is our feeling right now that we do know enough about whether or not people who thought they could get clean needles would not be motivated any longer to come in for treatment. That is the downside of that and is something we are concerned about.

We are attempting to get research in this area, but in the present period of time we are not prepared to recommend this as a policy.

Mr. RANGEL. Are there questions that panel board members may have of each other? Are there any more questions out there?

VOICE. I have a question for former Congressman Hansen.

Mr. RANGEL. Would you identify yourself, please?

VOICE. I am Donald Danemar from Group W News. I have a question about AIDS in prisons. How much at risk, if he is identified as someone who is either positive or as someone who got AIDS. Is he in danger from the other inmates?

Mr. HANSEN. I think that is a real problem. Even if a person doesn't have AIDS, if he has a lifestyle that scares some people, that they know he is a drug shooter or they suspect him of being a homosexual or something—will have notes passed to the hacks, as they call them, the officers, who will tell them you had better get him out of here or something is going to happen to him. It won't be a direct threat, but it is an implied threat, and of course, then the prison officials can't be remiss in some deference to them, so they have to do something with him—so here again that kind of threat doesn't cause any prosecution or any difficulty for the person issuing the threat.

It is the victim that goes to the hole for his own protection, so to speak, and until they can find some other place for him. The trouble is that the victim becomes a double victim under those circumstances, and of course, if somebody knew he had AIDS, he would come as a pariah, because again it is not so much what is real about AIDS as what is perceived, and when you get people in a confined circumstance, it makes a real problem, because they can't govern the facilities they use or anything else.

Now if you have an AIDS victim at home, it is a little different. You kind of get an agreement, you know, about which bathrooms and the sanitation facilities and a few things like that, but in prison you get thrown in with someone else into a cell or a cubicle or whatever, and you have no choice in the matter, and that is the problem you have, and then people react, and sometimes in very harsh ways.

Mr. TRAVISONO. Mr. Chairman, I just want to follow up on that question. There is some evidence just beginning to come forward, particularly in jails, where there is a little—I am going to say this

cautiously. The stigmatism of having AIDS is not what it might be in a prison. In fact, some men are suggesting that they have it to be left alone, and so a man with AIDS, we have just heard recently in two or three local jails, that the rest of the inmates give them a wide berth. They don't want to do what Mr. Hansen was suggesting, to get involved with this guy, and hurt them in any way, because in a jail they usually have a shorter sentence, whereas in a prison you may have several lifers in there whose attitude is take another life, who cares, so you have that dichotomy developing in the business at the moment.

VOICE. Can I ask one more question.

Mr. HANSEN. Before you ask the question, let me say this. As he mentioned there are different circumstances. When I was in the Alexandria jail, it wasn't an AIDS problem, it was a TB problem. They threw a person in there for three days that had tuberculosis, and that is contagious also, and when you are in jail, a lot of people, if this guy doesn't want his bread and that guy doesn't want his potatoes, they shift food around and everything else and here there was a lot of things going on like that, and then all at once here comes the authorities in with their masks and surgical gloves and take the guy out, but nobody says why and they just leave the rumors flying.

It is a lack of openness, Glasnost, as you say or fear that really keeps the tension level high, because people don't know what they have been exposed to, and they can react sometimes very violently.

VOICE. If I can ask Mr. Travisono a controversial question. Do you think it would be good idea in order to save lives, stop the spread of the disease, to distribute either condoms or clean needles for the prison population?

Mr. TRAVISONO. One state has developed a policy to distribute condoms, and that is Vermont, on medical request. There has been no evidence that anyone is wanting to do this with clean needles. In fact, it would be against the law, and either our courageous politicians would be the first to lash out at correctional officials who give clean needles, not only that but a lot of other people in the community, so I doubt that that will ever happen in our life time.

Mr. RANGEL. What are your views on the distribution of condoms?

Mr. TRAVISONO. The attitude of the correctional administrators right at the moment, Mr. Rangel, is that homosexuality is against the prison policy and condoms shouldn't be given out, to encourage breaking the law. We try to contain it as best we can.

Mr. HANSEN. Mr. Chairman.

Mr. Chairman, I was going to say it seems to me that if you want to carry that to the extreme, it is a bit of favoritism, if they don't allow conjugal visits, then why are they encouraging two inmates to play games with each other?

Mr. RANGEL. Again, I don't think our prison officials have been given the leeway to really discuss these things. That is the reason why, Mr. Travisono, I am not going to press you further, but I am going to encourage your association to start to get together and try to come up with some recommendations, because you are a dumping ground. We tell you to contain the problems and not to discuss it, but sooner or later you will find out, as we did in Attica, New

York, that there can be prisoners on both sides of the cell block, because you are restricted from speaking out on conditions. I know we are dealing with a dedicated hardworking group that sacrifices a lot of their freedom. But we can't get answers unless we all work together as a team on both sides, so I will be getting back to you Dr. Brown.

Dr. BROWN. Mr. Chairman, If I may add a comment, you asked me earlier do I refer to our enrollees as patients or clients. I want to underscore something, that I come to drug treatment as a physician first, and because drug abuse is a disease, there has been extensive evaluation in terms of the psychologic, physiologic conditions related to drug use, so that I think sometimes we need to step back, to look at it as we do other chronic diseases.

For example, I have no vested interest, I have no stock in methadone, but I do recognize that there are diabetics, for example, that need insulin, just as there are wide and vast modalities for treatment of diabetes, a chronic disease, there is a true wide and vast modality for treatment of drug abuse, another chronic disease.

Mr. RANGEL. What kinds of diseases, and I really ask this for informational purposes, do healthy people walk into on a voluntary basis? There are probably many. Dr. Schuster, I think is going to answer that.

Dr. SCHUSTER. Smoking.

Mr. RANGEL. That is true.

Dr. BROWN. The other thing is, we are not too sure that this is the case that healthy people walk in. There are a number of investigations that suggest that there may be some genetic predisposition so that this issue will not—and the fact that drug abuse is associated with one not having the will to do something, that they in fact are any lesser of a person, I think we need to understand that this sometimes gets in our way of being able to provide the scope of therapeutic modalities for the drug addicted.

Mr. RANGEL. Well, you more than answered my question, but I really think that some of those treatment modalities ought to be speaking out more about the social conditions which causes your patients not to be incurable, but the chances of recovery are very slim.

I mean, if you were to have a tuberculosis patient that lived in a place without heat and without water, and you were giving all of the medicines that were available, and yet this patient was an outpatient going back to the same condition—you know, you could not talk about a great success rate. We don't hear that type of talk.

Dr. BROWN. You are quite right. For chronic diseases, I think we need to change what are, in fact, yardsticks. We are not talking necessarily about cure. With the diabetes example I said earlier, we are talking about being able to control the disease process other than treating people's lives or putting them in jail or putting them behind treatment programs.

I mean, being able to control the disease process that manifests itself in physiologic psychologic, and economic consequences. We need to be able to provide intervention that will allow those individuals to be constructive contributors of society, and not get sometimes in the way of the fact that this means chronic treatment. I

mean, we have long ago accepted the analogies of the diabetics, the syringe that they have to take, many of them for the rest of their lives.

We need to understand that drug treatment also in most of the cases requires a lifelong legacy of those types of interventions.

Mr. RANGEL. What do you mean by intervention? We have to accept what? We have to accept the drug addicts as we do the diabetic?

Dr. BROWN. No, I think we have to accept there has to be a response, a generic, comprehensive response for the drug-addicted for the rest of his or her lives. The disease process may be arrested, may be in remission, but there is always the issue that the disease exists and many things in the environment can stimulate its exacerbation.

Mr. RANGEL. Dr. Schuster?

Dr. SCHUSTER. I certainly would agree, and you state it very eloquently. I would like to just make one point about methadone maintenance, because I think it is frequently misunderstood.

Methadone maintenance is not a drug treatment that is going to rehabilitate a heroin user. It will do exactly what it is intended to do, and that is to decrease the frequency with which this person will take an illicit opiate. It depends on whether or not the treatment program also has ancillary services for rehabilitation whether or not that is going to be accomplished, but it is also dependent upon something else.

There are people who come into these treatment programs for whom we do not have current technology that will rehabilitate them, and we have to admit that, and in those cases, I think that we have to recognize that we still have to continue treating the symptom of drug-taking by giving methadone.

Now, I want to point out one statistic that has recently emerged from a study by Mary Jeanne Kreek, Rockefeller University, because it is very relevant to today's discussion, and then I will stop.

She compared a group of people who were heroin addicts in 1978, some of whom came into treatment and others did not. In 1985, she compared the rates of seroprevalence for AIDS virus in those two groups. The group that came into treatment in 1978 showed a 10-percent seroprevalence rate. The group who did not come into treatment showed a 65-percent seroprevalence rate.

Now, that is the illustration of the fact that treatment prevented the acquisition of this AIDS virus in these people. Now, in New York City, we have the most unfortunate circumstance that probably 50 to 60 percent of the patients are already sero-positive, but that is not the case in other cities.

Tampa, Florida has IV heroin users, but the seroprevalence rates are 1 percent. We have got to move in there and prevent it from spreading.

Los Angeles is 15 percent, so although New York is almost past the point of being able to prevent heroin addiction, current heroin addicts from becoming sero-positive, we can do it in other cities, and we also have to begin working to prevent kids in New York from becoming heroin addicts.

Mr. RANGEL. Why is it so prevalent in New York and northern New Jersey? What is so unique about that area?

Dr. SCHUSTER. We are in the process of doing studies of needle-sharing practices, and one of the things that appears to be a little bit unique about New York is the tremendous numbers of shooting galleries. Shooting galleries are places, of course, where the pusher not only sells the drug, but in addition, he has the needles, syringe or eye-dropper and the complete works for rent there.

Hundreds of people may use that same syringe and needle in the course of a day. I have been told that in Los Angeles and other places, shooting galleries are just not as prevalent.

Mr. RANGEL. Dr. Brown, these ancillary support systems that Dr. Schuster mentioned, with the Addiction Research and Treatment Corporation do you have these support systems?

Dr. BROWN. Congressman, I wish I could say that we have a sufficient amount of that. We do not. And when we have a counselor-to-patient ratio of one counselor to 50 patients, it is difficult to be able to do a lot other than often provide treatment of the symptoms.

And I think that one of the reasons why I was glad I was offered the opportunity to come here was to be able to, in fact, raise that issue, so that we—and we have been very, very articulate, and you know, Dr. Benny Prim has been articulate about the issue that there needs to be greater services for those types of patients, given that these programs see these patients a greater proportion of their lives than any other institution.

Mr. RANGEL. And if I understand what the experts have said today, we need an educational system for people who are not addicts that are going to bed with IV drug addicts.

Dr. SCHUSTER. That is absolutely true. We need—part of the strategy which we have in our comprehensive grads is to actually go out and to find the sexual partners of IV drug users and to educate them to the risk that they are taking.

Not exclusively, but often these are women, and I think the primary way we can get them to think about this is through the issue of having a baby. We have new material in which we are preparing now for distribution in this group, and second, the message is, don't have a baby that is born to die, and I—it is—there is just no question that in the people who have seen this material who are part of this population, they have been very affected by the issue of seropositive—having babies who are going to have AIDS.

So, I think that we may have a shot at being able to get people to think about their behavior. If we don't stress so much their death, but rather the fact they are going to contribute to the death of a very young infant, then they may be more sensitive to that.

Mr. RANGEL. But you told me earlier, Dr. Schuster, that your research indicates the males are concerned about the—their potential child having AIDS. Dr. Hale, have you found the fathers showing this type of extraordinary concern about the children at the Hale House?

Ms. HALE. No, Congressman, we haven't. As a matter of fact, we haven't found any fathers, so that you know, our—we have begun to ask—how were these babies being conceived, if you will, but what we are finding is that the women who are pregnant and who have the virus are not very concerned with not having the baby.

They want to continue the pregnancy, because they feel they know they have been told that it is a 50-50 chance that the child

will not be born, will not have the virus, and therefore they would—their argument is, I want to leave something behind, so these are women who know they have the virus and they will continue the pregnancy and have the baby, so that they are willing, in my opinion, to risk the child because again, it is Russian roulette.

Mr. RANGEL. Dr. Schuster, there is a lot of evidence, and I am working with some social workers in New York, that these teenager mothers, for whatever psychological reasons, are forbidden to have these babies, notwithstanding the fact that they have no training in mothering, that many of them are sick, some are drug abusers and yet, there are some—no matter how much education they are exposed to, that there is some drive in believing they are worth something by having a baby; and that the social workers, black and white, truly believe that they are going to have to find different types of tools to convey to these kids themselves that they are part of the problem.

Dr. SCHUSTER. Well, I am aware of the fact that this is oftentimes a means of giving some type of self-identity. It is a means of giving some importance to their life, and I think the only thing I can say, which I said previously, is that we have to begin earlier.

If these children were to be at a much earlier age given some sense of identity, some sense of self-worth, they would not need than to simply have—to promiscuously have children in order to feel that they are doing something important. If they could find other avenues and alternatives in terms of feelings of self-importance at that early age until the age when it is appropriate for them to get married and have children.

That is the issue.

Ms. HALE. Congressman, if I may? My sense in working with these young women is that there is, first of all, a religious notion that if I get pregnant, God put the baby there. They have not really connected in a very real sense the sexual act as being the reason for the pregnancy. God wanted me to have a baby, is what I have heard over and over and over again in talking with these young women.

"If God didn't want me to have the baby, I would not have gotten pregnant. Doesn't m[illegible]r what I did." They don't see the cause and effect relationship.

Mr. RANGEL. That is why you need another subcommittee, Dr. Lee, with the spiritual leaders going on in and explaining what God really meant.

Dr. LEE. Why don't those girls know? They actually know, but they are just denying it, I take it.

Ms. HALE. I think there is a tremendous amount of denial, and for many of them, they simply do not know. They haven't reached that level of maturity where they could internalize what is being said to them.

Mr. RANGEL. I think the church, too, is in part responsible, because they talk a lot about life before birth, but they don't deal too much with life after birth, and so you assume your moral responsibility, which I think in the religious black experience has always been there, but now that you have done what God would want you to do, then where do you go, especially if you are an illiterate yourself?

How do you intend to set up your subcommittee, because you know, we have this Select Narcotics Committee, that is supposed to be in business just for two years, and then we are supposed to go out of business and throw the jurisdiction over to the standing committees. It is a very temporary thing.

Now, we are in business for how long—11 years, because the standing committees have not seen any direction in which they are going to go, and so we continue.

Dr. Lee, has your Commission ever thought about the idea that you may be around longer than your reporting period?

Dr. LEE. It has been my observation that the successful committees stay around and the unsuccessful ones don't, so we will see how my Commission does. One of the things that was brought up here is—which—it has always gotten to me since they closed Mattaway, you have all the criminally insane people in these jails and prisons, what percentage actually of psychiatric diagnoses that are relatively permanent in your prison systems, Mr. Travisono?

Mr. TRAVISONO. We don't have an answer to that question collectively throughout the United States. However the Dept. of HHS is helping collect that information right now, because many of our colleagues felt their agencies are the dumping grounds. Many of our new intake appear to have permanent diagnoses of schizophrenia.

We feel that way, but we are not sure we have the material to actually say it, so it is in the collection stage right at the moment.

Dr. LEE. Because the same situation exists—this AIDS thing is like an amoeba, just keeps branching into everything, and with the homeless, mental illness is—it is reported it is 50 percent, but I can't believe it isn't higher.

Who would really want to lie on a sidewalk at 20 degrees in sleet and rain unless you are mentally ill?

Dr. SCHUSTER. If I may comment on this, I think the statement that 50 percent are mentally ill should be properly stated that 50 percent can be diagnosed with current diagnostic criteria for disorders.

Maybe after the study, we could come up with other kinds of cases, because as you are suggesting, the current ones don't cover a large percentage of them who clearly seem to be acting in a way that is bizarre.

Mr. RANGEL. Well, I tell you this: I don't know anything about what you two are talking about, but if you have seen where they sent these homeless people to live in the shelters, in the armories and in the hotels, if you did not have a problem when you went in, I can see how clearly you would have one in getting off of the streets, and I can see why some people would resist being forced into these institutions, but you are really penetrating an area that people don't talk about, but why not talk about this drug addict in having some serious mental problems?

It may be like smoking cigarettes and obesity and all that, but to me, popping that poison in your veins, knowing that you have seen your friends die from overdoses and knowing that you constantly see people falling apart, and then coupled that with the fact that there is no reason to believe that you are ever going to be well in terms of joining your family or getting a job or being a tax produc-

er, to me there has to be some problems that even counselors can't reach, Dr. Brown, and where people really have to know that they have got problems beyond just abusing their bodies with drugs.

Dr. BROWN. That is most assuredly, and I guess in this era of the AIDS epidemic, only making that issue more prominent. The whole classification of abnormalities of AIDS dementia cropping up because of infection, and it is hard to tell the difference between many patients who may have had some derangements prior to the AIDS epidemic and subsequent to it, to be able to do that at the treatment clinic level, so for that reason, support systems need to be in place.

There is a big difficulty that just as there is stigmatism of the drug addict by the public in general, there is also stigmatism of the drug addict by many of the social services, including the medical profession. They are only a microcosm of the society.

Mr. RANGEL. But, Dr. Lee, with cancer patients, do you find that—you find changes in emotional behavior when people find out they are terminal or that they may have inherited a cancer, and would that not cause other mental type problems the same way someone who finds out that they could have AIDS?

Dr. LEE. Well, it has always amazed me. We have just finished with a psychosocial week of meetings at Memorial Hospital, dealing with cancer and AIDS. Speakers, many of whom are from Washington, were extremely interesting. I have always been impressed as being on the front lines of the cancer problem, and my life is taking care of them, how little emotional—how few crack under a death sentence, how few suicides—we see a few, but how very few we see.

But on this mental illness situation, I think the medical profession has always failed with alcoholism, deferring completely to all the experts in the drug field. I mean, basically, once somebody is a drug addict, medical intervention helps, but it doesn't seem to cure the problem.

The medical profession fails with this business. There is something else that is required. It is basic. You ask, do the people in the inner cities have a mental illness when they take drugs? Why are they injecting these foreign substances into them? You are really on to the core of it, in my opinion, and that is that hey, they are so goddamn desperate that is what they are doing. They didn't start off mentally ill, but by the time they are finished, they are permanently mentally ill, and something has to be done, as every speaker said, very early.

I want to hear, I want to be able to present at some point in the next year, how do we put that family back together again? How do we get the responsible father back together again? When I listened to Lorraine Hale, hey, there are no black fathers, what is it 49 to 100, but they are there. I mean, we have to get them back.

Ms. HALE. If I can respond?

Mr. RANGEL. Yes.

Ms. HALE. My sense is that we are a foster care agency. If you want to know how to get the family back together, you do it by supporting the mothers, supporting the existing family. You don't remove children from their parents so that you can place them someplace else, pay other people to take care of them.

It seems to me, Congressman, that the money that is expended in foster care could be—much of it could be well advised spent in restoring families, but in maintaining families and helping families, the same kind of education that is given to foster parents so that they can learn how to be better parents to children certainly could be given to natural parents, natural families.

I have been dismayed any number of times at seeing children removed from families for situations that I felt could have been—the family could have been helped, because once you have removed the child, you have destroyed the family, and it is very difficult to put those families together again.

The women with whom we worked, 40 percent of those who have been—within foster care themselves, 50 percent claimed to have been sexually assaulted in the foster family home, and yet we continue to push this foster family as the only solution to a very complicated problem, when I would certainly like to see the money, or much of it used to restore the family as it exists.

It may not be ideal, according to someone else's notion of an ideal family, but it certainly can be better than many of the homes that the children are put in.

Mr. RANGEL. Dr. Hale, you make a lot of sense, but we are talking about budget deficits, and we are talking about political decisions being made as to how money will be spent, and you are talking about avoiding the crisis.

You are talking about maintaining the family unit, keeping the kid in the house. You are talking about people who don't appear to be causing a problem, and that is where you will find that people aren't willing to make that investment.

They would rather wait until the problem is there and then respond to it with very little resources. I will be meeting with the New York State social workers—I mean, if you really want a bite of something, you ought to take a look at the Federal Emergency Fund's housing flowing to the city. Supposed to be for 30 days.

This Administration found that we are paying $37,000 a year for welfare families to be holed up in hotels in little rooms, and so they are going to cut off the Federal funds. The city wants the Federal funds, but they haven't shown how they are going to take families out of the welfare hotels, and we are talking about roach-infested, kids are not going to school, a place for them to play.

Now, something is wrong with the bureaucracy if we are going to invest close to $40,000 a year for these people to live in these little rooms, but again, there is no alternative because of the reimbursement system. The city doesn't get the money for permanent housing; the city doesn't get the money for education; the city doesn't get the money to help families stay together; doesn't get money to teach somebody how to get the skills and to get the job so that they will not have to be on welfare. But I am going to share what happens at that conference with you, Dr. Lee, and with you, Dr. Hale, because everyone is coming up with the problems, but very few people are coming together to establish as the political priority to help these people before they become not only a social problem, but a very costly deficit problem.

It costs to keep these people in jail, and it costs even more in what you are turning out of the jails.

Ms. HALE. But I think there are things that we do know. For example, we do know that there is a 10-percent factor. We know that there are some 25 million Americans who have a predisposition for drug use.

It seems to me that when we begin to talk about education, we should begin to talk from that vantagepoint. We know that if a child is in a home with a parent who is an alcoholic or a drug addict, that child is at 10-percent risk of becoming an alcoholic or drug addict.

We know that and it seems to me that is where you would want to start. When there are both parents who are abusing drugs, who are alcoholics, that child is at 437 percent risk of using drugs, some kind of drug. But, also there is a predisposition. This is a child who will take a drink of wine at 14 or 15, and will continue from there, because they can't stop or they don't want to stop.

That is the kind of educational—educational information I would like to see those youngsters have, so that they—there is prevention at an early stage.

Mr. RANGEL. Well, that is the roughest thing for us to deal with. No question of what you are saying makes a lot of good common sense, and the record is going to remain open for recommendations or suggestions that you all have, and I would want all of you to know, as I promised Dr. Heagarty, that I will be in touch with you to see what support, not just the select committee can give to the work you are doing, but the committee that may have legislative jurisdiction. So, if it is not my job, I will find out whose job it is.

I thank you for the contribution you have made today, and I hope this will be the beginning. As I told Congressman Hansen, we could reach out and try to get more of our skills together to see how we can form this political system in such a way that doing the right thing is an acceptable political thing to do. And, again, I am relying heavily on the President's Commission, because they are going to be presenting some rough problems to the President, and we are going to have to get to the drawing board to see how we can find some answers to it.

Thank you very much. The committee stands adjourned, subject to the call of the Chair.

[Whereupon, at 1 p.m., the select committee adjourned subject to the call of the Chair.]

PREPARED STATEMENTS

OPENING STATEMENT

OF

THE HONORABLE CHARLES B. RANGEL

FOR

HEARING ON

INTRAVENOUS DRUG ABUSE AND AIDS:

IMPACT ON THE BLACK COMMUNITY

BEFORE

THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

SEPTEMBER 25, 1987

I WOULD LIKE TO EXTEND A WELCOME TO OUR WITNESSES AND GUESTS. THIS MORNING, AS PART OF THE 17TH ANNUAL CONGRESSIONAL BLACK CAUCUS WEEKEND, THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HAS INVITED A WIDE RANGE OF WITNESSES TO DISCUSS THE IMPACT OF AIDS AND INTRAVENOUS DRUG ABUSE ON THE BLACK COMMUNITY.

AIDS IS PERHAPS THE MOST SERIOUS HEALTH PROBLEM EVER CONFRONTED BY THIS NATION. IT IS, AS SOME EXPERTS SAY, THE NEW PLAGUE. ALREADY THERE HAVE BEEN 40,000 REPORTED AIDS CASES. THOUSANDS MORE ARE INFECTED WITH THE HIV VIRUS. AMONG THE VICTIMS OF AIDS, WE, IN THE BLACK COMMUNITY ARE OVERREPRESENTED. AIDS IS A HEALTH PROBLEM TO THE NATION, BUT IT IS A THREAT TO THE VERY SURVIVAL OF THE BLACK COMMUNITY.

WHY ARE OUR MEN, WOMEN, AND CHILDREN FOUND DISPROPORTIONATELY AMONG THE VICTIMS OF AIDS? THE ANSWER IS SIMPLE -- INTRAVENOUS DRUG ABUSE.

THROUGH THE USE AND SHARING OF NEEDLES, SYRINGES, SWABS, OR OTHER DRUG-RELATED IMPLEMENTS, CONTAMINATED WITH HIV INFECTED BLOOD, AIDS IS RAPIDLY TRANSMITTED AMONG IV DRUG USERS. AMONG ALL AIDS CASES, INTRAVENOUS DRUG ABUSE IS THE SECOND MOST FREQUENT MEANS OF TRANSMITTING THE AIDS VIRUS. APPROXIMATELY ONE FOURTH OF ALL AIDS CASES INVOLVE INTRAVENOUS DRUG USE. IN THE BLACK COMMUNITY, HOWEVER, THE RATE OF ASSOCIATION BETWEEN AIDS AND IV DRUG ABUSE IS MUCH HIGHER.

AMONG BLACK MALES WITH AIDS, IV DRUG USE IS THE SOLE OR A CONTRIBUTING FACTOR IN MORE THAN 40 PERCENT OF REPORTED CASES. AMONG WOMEN WITH AIDS, 50 PERCENT ARE IV DRUG ABUSERS. THE SECOND LARGEST GROUP OF WOMEN VULNERABLE TO AIDS ARE THE SEXUAL PARTNERS OF IV DRUG USERS. MOST OF THESE WOMEN ARE BLACK OR HISPANIC. SIMILARLY, IV DRUG USE IS THE SOURCE OF MOST PEDIATRIC AIDS CASES; 90 PERCENT OF THESE CHILDREN ARE BLACK OR HISPANIC. THE AIDS/IV DRUG CONNECTION IS KILLING OUR MEN, WOMEN AND CHILDREN.

IF WE ARE TO PROTECT OUR COMMUNITY, OUR FAMILIES, AND OUR CHILDREN FROM THIS DEADLY VIRUS, WE CANNOT AFFORD TO DENY THE STATISTICS. WE MUST RESPOND TO THE IV DRUG ABUSE PROBLEM AND WE MUST RESPOND QUICKLY.

OF THE APPROXIMATELY 1.2 MILLION IV DRUG USERS IN THIS COUNTRY, HALF ARE BLACK. IT IS ESTIMATED THAT 250,000 TO 300,000 IV DRUG USERS HAVE BEEN INFECTED WITH THE AIDS VIRUS. IN NEW YORK, STUDIES INDICATE THAT HALF OF THOSE IN DRUG TREATMENT PROGRAMS ARE INFECTED WITH THE AIDS VIRUS. OUR FIRST LINE OF DEFENSE IS TO REACH OUT TO THOSE IN DRUG TREATMENT TO ENSURE THAT THEY ARE AWARE OF BOTH THEIR OWN VULNERABILITY TO AIDS AND THE EASE WITH WHICH THEY CAN TRANSMIT THE DISEASE TO THEIR SEXUAL PARTNER AND UNBORN CHILDREN.

INDIVIDUALS IN DRUG TREATMENT, HOWEVER, CONSTITUTE ONLY 1 OUT OF 6 IV DRUG USERS. THEREFORE, WE MUST ALSO REACH INTO THE COMMUNITY TO FIND THOSE WHO ARE ABUSING DRUGS AND ARE NOT IN TREATMENT. AS DIFFICULT AS IT MAY BE, WE MUST COMMUNICATE TO

THEM THE DANGERS OF THEIR DRUG ABUSING BEHAVIOR, URGE THEM TO ENTER TREATMENT AND TO CHANGE THEIR BEHAVIOR TO REDUCE THE RISK OF AIDS TRANSMISSION. REACHING THOSE WHO HAVE LOST HOPE IS AN ALMOST IMPOSSIBLE TASK, BUT OUR SURVIVAL DEPENDS ON OUR SUCCEEDING.

AND, WE MUST REACH INTO OUR PRISONS. ACCORDING TO THE FEDERAL BUREAU OF PRISONS, APPROXIMATELY 75 PERCENT OF THOSE WITH AIDS ENTERING FEDERAL PRISONS ARE INTRAVENOUS DRUG ABUSERS. MOST OF THESE INDIVIDUALS, ESPECIALLY THOSE INFECTED WITH THE HIV VIRUS WHO HAVE NOT DEVELOPED THE DISEASE, WILL EVENTUALLY RETURN TO THEIR COMMUNITIES. MANY OF THEM WILL BE RETURNING TO OUR BLACK COMMUNITIES, BECAUSE AS YOU WELL KNOW, BLACKS ARE OVERREPRESENTED IN THE PRISON POPULATION.

THIS MORNING WE WILL EXAMINE THE IMPACT OF THE AIDS/IV DRUG PROBLEM ON OUR COMMUNITY. OUR WITNESSES WILL DISCUSS THE DIMENSIONS OF THE PROBLEM, PEDIATRIC AIDS, AIDS IN PRISONS, COMMUNITY EFFORTS TO COMBAT AIDS, AND AIDS AND DRUG ABUSE TREATMENT. WE WILL ALLOW YOU TO ASK QUESTIONS AT APPROPRIATE POINTS IN THE PROCEEDING. I BELIEVE WE WILL HAVE AN EXCITING DISCUSSION.

LET ME CLOSE BY SAYING THAT I FIRMLY BELIEVE THAT WE IN THE CONGRESS MUST PLAY A LEADERSHIP ROLE IN THE FIGHT AGAINST AIDS. ACCORDINGLY, I HAVE INTRODUCED TWO PIECES OF LEGISLATION DIRECTED TOWARD ADDRESSING THE AIDS PROBLEM. H.R. 3292, THE "INTRAVENOUS SUBSTANCE ABUSE AND AIDS PREVENTION ACT OF 1987" PROVIDES $200 MILLION FOR DRUG ABUSE TREATMENT, AIDS COUNSELING,

AND AIDS TESTING FOR IV DRUG USERS; $100 MILLION FOR PEDIATRIC AIDS-RELATED SERVICES; AND $100 MILLION FOR AIDS PREVENTION EDUCATION. H.R. 2626, INTRODUCED BY MR. KENNEDY IN THE SENATE, WOULD AUTHORIZE $550 MILLION FOR FISCAL YEAR 1987 FOR AIDS EDUCATION AND RESEARCH.

LEGISLATION IS, HOWEVER, ONLY ONE LINE OF DEFENSE AGAINST AIDS. TO IMMUNIZE AND PROTECT OUR COMMUNITIES FROM THE AIDS EPIDEMIC, TO STOP THE SPREAD OF THIS DISEASE IN ITS TRACKS, WE WILL NEED THE HELP AND SUPPORT OF ALL SEGMENTS OF THE COMMUNITY -- GOVERNMENT, BUSINESS, RELIGIOUS LEADERS, EDUCATORS, THE MEDICAL PROFESSION, AND CITIZENS. WE IN THE BLACK COMMUNITY HAVE A SPECIAL ROLE TO PLAY, A VITAL ROLE TO PLAY, BECAUSE THE VERY SURVIVAL OF OUR COMMUNITY DEPENDS ON HOW QUICKLY AND EFFECTIVELY WE CAN MAKE AIDS A DISEASE OF OUR PAST.

STATEMENT BY CHARLES R. SCHUSTER, PH.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Mr. Chairman, members of the Committee, and members of the Congressional Black Caucus, I am Dr. Charles R. Schuster, Director of the National Institute on Drug Abuse (NIDA) of the Alcohol, Drug Abuse, and Mental Health Administration. We are grateful for this opportunity to participate in this hearing on the impact of drug abuse and acquired immune deficiency syndrome (AIDS) on the minority communities.

NATURE AND EXTENT OF THE PROBLEM

Many Black communities in this country face two major epidemics today, drug abuse and AIDS—and there is a close connection between these two life-threatening diseases. We at NIDA are well aware that Black inner city communities are disproportionately affected by these tragic problems and we are mounting special initiatives to reduce the incidence of drug abuse and control the spread of AIDS in these communities.

Before I describe these initiatives, I would like to review some of the facts. Epidemiologists have conservatively estimated that there are approximately 1.2 million intravenous drug abusers in the country at this time and about 54 percent are Black. It is not surprising then to find that Blacks are overrepresented among those who have gotten AIDS since intravenous drug use—specifically the sharing of needles or works with contaminated blood—is one of the primary ways that the AIDS virus is spread.

Data collected and compiled by the Centers for Disease Control indicate that IV drug abusers make up one-quarter of all AIDS cases. The statistics show that 65 percent of all IV drug abusers with AIDS are Black or Hispanic.

But the CDC AIDS data are only part of the story, the tip of the iceberg. It has been estimated that approximately 250,000 to 300,000 intravenous drug abusers may already be infected with the AIDS virus. Seroprevalence studies of drug abuse clients in treatment indicate that more than 50 percent of all the clients in New York City and northern New Jersey are already infected with the virus. Yet only one of six heroin addicts is in treatment at any one time. At this time, we know relatively little about the rates of infection among IV drug abusers who are not in treatment. We have no idea, as to, how many sexual partners or children of IV drug users may be infected. We do know that IV drug abusers are transmitting the virus through sexual contact to their sexual partners and that their sexual partners are transmitting it to their children. In fact, the rate of heterosexually transmitted AIDS is 17 times higher among Blacks than among Whites. Approximately 73 percent of the pediatric AIDS cases are associated with transmission from an infected mother and it is estimated that 50 percent of the babies born to HIV infected mothers will also be infected with the virus.

Accumulative incidences of pediatric AIDS cases show that Blacks are over-represented by a factor of 15. A majority of infant AIDS cases are born to Black IV drug abusing women.

PREVENTION AND INTERVENTION

In general, IV drug abusers are difficult to reach. They tend to be heroin addicts, poorly educated, living in the inner-city part of large urban areas, and fall into the lower city socioeconomic strata. They also have high rates of psychopathology and criminality and often have unattended medical problems. In addition, because of their involvement with illicit substance abuse as well as other criminal activities, they tend to be distrustful of authority and seek personal anonymity. As a result, even the identification of heroin addicts is a difficult problem. Presenting educational material to them in a manner than is understood and trusted is doubly difficult.

A further challenge lies in the fact that many non-IV drug using people are also at high risk if they are unaware that their sexual partners are drug addicts. Therefore, they have no reason to suspect that they are at risk for infection with the AIDS virus. If they become infected, they may pass on the virus to other sexual partners without suspecting that they are doing so; and for women, they could also pass on the infection to their children.

Now even when high risk individuals can be contacted, it is important to recognize that it is extremely difficult to change health and sexual behaviors. Researchers in the area of health behavior change have learned that one's ability to utilize health education information and to make changes in one's behavior largely depends on socioeconomic status, educational level, sense of power and control, and

one's vocation. For example, women who are likely to be the sexual partners of IV drug abusers have low socioeconomic status, a low educational level, a sense of powerlessness and helplessness, and may be either unemployed or work as prostitutes.

For both male and female drug addicts, the first and foremost message must be to stop using drugs intravenously. But for those who cannot or will not stop, preventing the spread of AIDS requires behavior change in two areas. To prevent transmission via infected needles, they must stop sharing "works" or learn to sterilize injection equipment properly. In order to prevent sexual transmission or transmission *in utero*, sexual practices and relationships may need to be modified or disrupted and, in some cases, they may need to give serious consideration to the advisability of having children.

In an attempt to bring about sustained behavior change in persons at high risk, we must find them, gain their trust, and provide culturally sensitive education and prevention programs. For those who are addicted to drugs, we must continue to expand the availability of drug abuse outreach and treatment services. We must continue to support research that will improve our efforts to treat and prevent IV drug abuse.

NIDA'S RESPONSE

The National Institute on Drug Abuse has taken a number of initiatives to reduce the spread of AIDS among IV drug abusers, their sexual partners and their children. All these activities are relevant to the health and welfare of all Americans, regardless of color or ethnicity, but the Institute is particularly committed to focusing projects and resources on the special needs of the minority community.

First let me talk about our educational programs:

NIDA has designed and implemented as series of AIDS training programs for the staff of the State drug abuse authorities, drug treatment programs and agencies that serve or come into contact with IV drug abusers, their sexual partners and/or prostitutes. So far, training has been delivered to more than 2,300 drug abuse counselors and administrators in 23 States. Through NIDA's Training of Trainers' program, more than 90 individuals at the State level have been taught to deliver NIDA's AIDS training program. More than half the trainers are Black.

NIDA is placing special emphasis on reaching and effectively communicating information about AIDS to minority groups. For example we recently have had, in coordination with the Congress of National Black Churches a meeting entitled, "AIDS Crisis in Black America Leadership Consultation." More than 30 church leaders participated to become educated on the extent of drug abuse and AIDS in the Black community, the relationship between AIDS and drug abuse, NIDA's AIDS initiatives, and an overview of programs initiated by some of the participating clergy. A major outcome of the meeting was an agreement among the participants to mount a unified effort to develop a model for an AIDS and drug abuse education program.

NIDA is also concerned with the many policy issues that surround the problems of AIDS and IV drug abuse and we're holding technical review meetings in which scholars, scientists, researchers, et cetera are called in to give us the back to votes and practitioners can come together to share information about specific issues, such as mandatory treatment, needle sharing, and the possibility that using certain abused substances (nitrities, or "poppers") might increase the risk of Kaposi's sarcoma among AIDS victims. Linkages have been established between NIDA and State drug abuse authorities, and NIDA is providing technical assistance and consultation on policy and programmatic issues and initiatives.

NIDA's Drug Abuse Information and Referral Line (1-800-662-HELP) provides drug abuse treatment referrals to State and local programs throughout the country. In addition, it provides general information about drug abuse. This hotline will be advertised widely, later this fall, as a resource through which drug abusers and their significant others can receive information about IF drug abuse and AIDS, as well as referrals to testing and treatment programs in their local communities.

NIDA is in the process of launching, nationwide, a $10 million Community-based AIDS Outreach/Prevention Project targeted to IV drug abusers, their sexual partners and prostitutes in inner city communities. Through this demonstration grant program many thousands of individuals at high risk for AIDS will be reached quickly and educated regarding the risks associated with AIDS and on how to change behavior that places them at risk. As part of this effort, comprehensive outreach programs are being established in New York, Philadel-

phia, Miami, Chicago and San Francisco. In addition, more specialized outreach programs are being initiated in 15 other cities. All of these outreach efforts are being coordinated at the national level so that the participating agencies and organizations will be in a position to guage their effectiveness of different outreach approaches. In addition to this coordination of participating groups, there will be coordination among all levels of government, and this will include collaboration with the Centers for Disease Control and State and local health departments.

Five other research grant announcements that target specific aspects of the epidemic were issued, and they have drawn an excellent response from the scientific community. These announcements deal with changing high risk behaviors, research on the clinical epidemiology and natural history of HIV infection and AIDS, and basic research to determine the effects of abused drugs on the immune system.

NIDA is preparing a special research grant announcement for release in FY 88. It will solicit applications for Acquired Immunodeficiency Syndrome Research Centers, and is designed to complement the regular research grants program by providing long-term support for multidisciplinary preclinical and clinical research concerning AIDS, HIV infection, and drug abuse. The program is intended to attract investigators in the behavioral, biomedical, public health, and social sciences to study research problems related to the pathogenesis and prevention of AIDS and HIV infection. A center is expected to become a significant regional or national research resource. Applications that address minority issues and AIDS will be given priority.

NIDA is also designing a training program to teach professionals how to reach and communicate AIDS information to innercity teenage groups at high risk to use IV drugs or to associate with IV drug abusers—including runaways, school dropouts, and youngsters who live in areas where IV drug abuse is prevalent.

In collaboration with the Department of Housing and Urban Development, NIDA will conduct a demonstration project aimed at reducing the prevalence of drug abuse and the spread of AIDS in three to five housing developments, of which at least two are occupied by a large number of minority tenants. Each cooperating housing authority will identify a tenant leader who will serve as a paid community drug abuse coordinator. NIDA will train these individuals to assess the nature of the drug abuse problem in the housing development, identify community resources that can be mobilized to combat the problem, stimulate tenants to join in the drug abuse prevention effort, work with State and local drug treatment and prevention programs, and implement activities to prevent the transmission of the AIDS virus. NIDA will support the assessment of prevention and treatment programs that may be established within the housing developments, and will provide for evaluation of the overall intervention strategy.

To sum up, we share with you a great concern about the effect of AIDS on minority communities. NIDA is committed to expending resources and energy on the defeat of both AIDS and IV drug abuse. We look forward to continued and expanded collaboration with the Black community in the struggle to overcome this terrible epidemic.

To Accompany Remarks by Gary R. Noble, M.D., AIDS Coordinator, Public Health Service

[Keynote address: National Conference on AIDS in Minority Population in the United States presented in Atlanta, Georgia on August 8, 1987 by Donald R. Hopkins, M.D., M.P.H., Assistant Surgeon General, Deputy Director, Centers for Disease Control]

BACKGROUND MATERIAL

In discussing the problem of AIDS and HIV infection in minority U.S. populations, I want to first give a brief overview of the dimensions of the problem itself, then consider some differences in black and Hispanic communities which are relevant to the problem and its solution. I shall then review some of the actions which have been taken already to help address that problem, and finally, share some of my own thoughts about what needs to be done.

I should note at the outset that so far, the relative risk for AIDS among native Americans and among Asians and Pacific Islanders residing in the U.S. is small, less than that of the overall white U.S. population. For that reason, and because the problem of AIDS is so much greater in black and Hispanic communities in the U.S., most of my remarks here will pertain to the latter two minority groups. That is not

to imply however, that native Americans, Asians, and Pacific Islanders don't need to be alert to this threat and take steps to protect themselves. They do.

THE PROBLEM

As of September 14, of the cases of AIDS reported to date in the U.S., 25,270 were white, 9,911 were black, and 5,678 were Hispanic. Thus, although a majority, 61 percent, of these cases were in whites, blacks and Hispanics contributed twice as many persons to those totals as would be expected. Blacks, who comprise 12 percent of the U.S. population, constitute 24 percent of the AIDS cases. Hispanics, who comprise 7 percent of the U.S. population, constitute 14 percent of all the AIDS cases.

Fifty-four percent of all AIDS cases under 13 years at the time of diagnosis are black, and 24 percent of those under 13 years are Hispanic; thus 78 percent of all children with AIDS are minority populations. Among cases in women, 52 percent are in blacks, and 19 percent are in Hispanic women.

Persons in minority communities who are infected with the AIDS virus were infected by one of the same ways as everybody else was infected: by sexual contract; perinatally; or parenterally, through IV drug abuse or transfusion, but there are important differences in the proportions of persons infected by the different modes of transmission: whereas 12 percent of white men with AIDS are IV drug abusers or who had sex partners who were IV drug abusers, fully 40 percent of black and Hispanic men with AIDS fall in that category. Among women with AIDS, the proportion who were IV drug abusers or whose sex partners were IV drug abusers is 48 percent for whites, 70 percent for blacks, and 82 percent for Hispanics.

Among children with AIDS, 31 percent of white patients were born to mothers who had a history of IV drug abuse themselves or to mothers whose sex partner had a history of IV drug abuse. The comparable percentages for black and Hispanic children with AIDS are 61 percent and 76 percent, respectively.

Thus, IV drug abuse is associated with much of the AIDS transmission among blacks and Hispanics in the U.S. That association is maintained by parenterally-acquired infections, mostly due to IV drug abuse and sharing of needles and paraphernalia, as well as by secondary sexual and perinatal transmission.

Geographically, almost two-thirds of blacks (57.9%) and Hispanic (61.3%) adults who have AIDS live in New York, New Jersey, or Florida, vs. 29.5 percent of white adult AIDS patients. A total of 73.3 percent of black children with AIDS and 3.0 percent of Hispanic children with AIDS are found in the same three States.

All of the above-mentioned data are derived from persons diagnosed with AIDS. But the real problem in terms of spread of the disease is from the infected, asymptomatic, infectious persons. When we consider the prevalence rates of HIV antibody among the civilian applicants for the military service we find that there are 0.8 per 1000 for whites, 1.0/1000 for Native Americans, Asians, and Pacific Islanders but it's 2.3/1000 for Hispanics and 4.1/1000 for blacks and among blood donors examined in Atlanta, Baltimore, and Los Angeles we find that HIV antibodies were the 2/10,000 among whites, 9/10,000 among Hispanics, and 31/10,000 among the blacks population.

Jim Curran has calculated that if the estimated 1.5 million infected Americans are distributed similarly to the 40,000 persons diagnosed with AIDS so far, then about 0.5 percent of the white U.S. population is infected with HIV, and about 1.5 percent of the Hispanic and black populations are infected. Indeed, in a predominantly black and Hispanic population of women seen at a prenatal clinic in Brooklyn in 1986, Minkoff found 2.4 percent to be serologically positive for HIV.

Since infection with HIV is known to exacerbate tuberculosis infections, which * * * minorities. In New York City, Drs. Stoneburner and DesSarlais have documented increases in death rates from tuberculosis, pneumonia, endocarditis, and other unexplained deaths, paralleling increases in deaths from AIDS, suggesting that infection with HIV is probably associated with many other deaths not directly attributed to it.

RELEVANT DIFFERENCES IN BLACK AND HISPANIC COMMUNITIES

In addressing the problem of AIDS and HIV infection among blacks and Hispanics, we need to carefully consider what aspects of those communities or cultures are different in any way that is relevant to the struggle against this disease.

As we have already seen, the higher rates of *IV drug abuse*, which are not unrelated to higher rates of unemployment and inadequate education in the same two groups, are associated with disproportionately high rates of infection with HIV. One result of that is that nearly half of the black and Hispanic persons with AIDS are *heterosexual* (as compared to less than 15 percent of white cases). In blacks at least,

among the remaining non-heterosexual adults with AIDS, a significantly larger proportion of the black men appear to be *bisexual*, as compared to white men. In a certain sense then, AIDS may be said to already be a problem in black and Hispanic heterosexual communities.

Even among IV drug abusers in New York City, there appear to be important differences associated with race. A study by Schoenbaum and others showed that only 14 percent of white IV drug abusers tested were seropositive for HIV, whereas 42 percent of black and Hispanic drug abusers in the same area were seropositive. This was associated with the difference that 18 percent of the white addicts, but only 8 percent of the black and Hispanic addicts reported using new needles at least half the time.

Among Hispanics affected by AIDS in the northeastern U.S., 80–90 percent were born in Puerto Rico. In Florida, 33 percent of the black persons with AIDS were born in Haiti.

Potential barriers to reaching black and Hispanic groups in the U.S. include language, and differences in print news media and radio channels patronized. They also may include a heightened suspicion of "government" and its representatives, as well as fear of anything which might provide another excuse for discrimination.

It is crucial that we heed certain indications also of important differences in understanding and perception of AIDS, HIV infection, and control measures in minority communities. Dr. Susan Blake at the American Red Cross National Headquarters conducted a study of all published national public opinion polls on AIDS since 1983. In the preliminary analysis, a few areas of differences between responses of whites vs. other races are of interest:

(1) *Minorities are more likely to have misconceptions about some alleged modes of transmission.* In 1987, 12 percent of whites thought casual contact could result in AIDS vs. 25 percent of minorities. According to a poll of 1015 New York City adults conducted by the Gallup Organization, 28 percent of whites there believed a person could catch AIDS by donating blood; among black and Hispanic respondents 54 percent and 60 percent respectively, were similarly misinformed. (All were well aware of risk of sharing needles and male homosexual activity). These misconceptions need to be corrected.

(2) Not surprisingly in light of the above, many *more minorities reported feeling personally vulnerable, fearful, and/or concerned about AIDS:* typically 32 percent of minorities polled in 1987 vs. 15 percent of whites. Two specific recent polls which support that conclusion were conducted by the Illinois Department of Public Health, which found blacks and Hispanics to be among the least knowledgeable and most fearful of AIDS, and a nationwide poll of 2095 persons conducted for the Los Angeles Times, which found anxiety about AIDS was highest among blacks. These fears need to be channeled into constructive action.

(3) One positive difference is a reportedly *higher level of interest in reading or watching programs about AIDS.* Sixty-four percent of minorities said they would read or watch an entire article or program about AIDS, vs. 42 percent of whites, in 1987.

(4) Even more important, when asked in a 1986 poll whether they *had altered their sexual behavior* in any way to protect themselves against AIDS, 4 percent of whites said yes, whereas 25 percent of minorities said yes. In particular this appears to have referred to limiting number of sexual partners.

Finally, Dr. Blake reports that recent polls indicate that more minorities express an interest in doing more to help in the fight against AIDS , but they also advocate quarantine and other restrictions as control measures.

These and other such data must be verified and related to specific populations and geographic areas, but they can provide some valuable leads in addressing this problem of AIDS and HIV infection in minorities. Clearly, some important messages appear not to be getting through to some minority populations as well as to the white population, while some other messages apparently are.

WHAT'S BEING DONE?

Before turning to a few of my own thoughts about what needs to be done, I want to review quickly some of the actions which already are being taken.

Of the prevention and control activities being funded by the Centers for Disease Control (CDC), several have been directed specifically toward black or Hispanic populations. For example:

Of the 55 AIDS Health Education/Risk Reduction (HE/RR) programs, 15 (28%) have activities aimed at their Hispanic populations and 21 (38%) have targeted informational services to the black community. When these grants

were renewed in FY 1987, all grantees will be required to explicitly address the problem in their black and Hispanic populations, and to involve representatives of those groups.

Two of the 5 HE/RR community demonstration projects (Chicago, Ill; Long Beach, California) include specific minority elements (total award to these two: $2.0 million).

The FY 88 prevention of perinatal AIDS initiative ($6.1 m) is targeted mainly at black and Hispanic populations in New York City, northern New Jersey and Miami.

The school health initiative includes $100,000 each specifically for Hispanic, black national organizations to help increase involvement of schools.

There's a $4.6 million contract signed a week ago with Ogilvy and Mather Public Affairs, to develop a national media campaign. There is a subcontractor, the Lockhart and Pettus Agency of New York, to help with advertising aimed directly at the black target audiences, and another subcontractor, Sosa and Associates of San Antonio to address the Hispanic population.

In this fiscal year an additional $7 million is being made available for AIDS education and prevention among minorities, and in FY 88, $10 million has been requested of which $3 million in direct funding is to be awarded competitively to national minority organizations for AIDS education and prevention.

This conference itself of course is another milestone in our efforts to draw more attention to this aspect of the AIDS problem, seek solutions, and to help mobilize the affected communities themselves on this issue.

While minorities also benefit from programs aimed at the U.S. population in general, programs of the type just cited are clearly needed to supplement those other efforts.

WHAT SHOULD BE DONE?

Given that AIDS and HIV infection is such a serious problem in some black and Hispanic communities especially, how best to address it? How can the increasingly evident interest and concern be focused most effectively?

First, we must be careful to understand the enemy clearly. As I have tried to indicate, we are faced with a formidable combination of a deadly virus, IV drug abuse, and sexual promiscuity. We cannot ignore either of these three if we hope to succeed. All three must be attacked as vigorously as we can. We must not let sensitivity or embarrassment about discussing drug abuse and sexual promiscuity in minority communities impede our ability to address those urgent problems. They are not pleasant topics but the alternative to facing up to them is worse.

Second, we need to use the same interventions being used in the white community, although in different proportions, because of variations in the distribution of behavioral risks. Some different channels of communication are also needed. Whatever the channel, however, these interventions must be based on science, not sentiment. This challenge calls for reason and resources, not rhetoric or rationalization. As one of my medical school professors used to say, "If, while visiting a house of ill-repute, you discover it is on fire, and that a crowd has gathered outside, don't compound your mistake by hesitating to run out simply because you shouldn't have been there in the first place".

Third, we need to urge people who are or may be at risk, to be voluntarily tested. The greatest source of new infestions are the hundreds of thousands of asymptomatic infected people who don't know they are infected. Far too little has been made of the importance of such knowledge to the infected persons' own health, besides its critical importance to preventing further spread of infection sexually, perinatally and by sharing needles.

Fourth, there is a great need to promote cooperation. These is more than enough work to go around. It is gratifying to see the range and number of organizations, groups and individuals represented at this conference. We must ask not only what the Federal government can do for us, but also what we can do for ourselves and for all those infected persons. Some of what we can do includes helping provide social and medical support, as well as informed advocacy. For example, AIDS will not be controlled in black and Hispanic communities without more effective prevention of drug abuse, and widespread access to treatment slots for drug abusers.

Fifth, we should remember that this is an international problem. As bad a situation as we find ourselves in in the U.S., some of our kinsmen abroad are even worse off. Our problem will not be solved until their problem is solved. And not one of us chose to be born in San Francisco rather than Sao Paulo; or in Kinshasa rather than Kansas City.

Sixth, we must also remember that this is not the only important public health problem in minority communities. The report of the Secretary's Task Force on Black and Minority Health, on which I served, was published two years ago this month. At the time infectious diseases were not even ranked among the six most important causes of excess death in minorities. Those other problems have not disappeared. AIDS is a seventh Horseman of the Apocalypse. Someone who dies of lung cancer caused by cigarette smoking is just as dead, and that death is just as preventable, as someone else who succombs to pneumocystis pneumonia. Indeed, if we could only persuade all cigarette smokers to quit, and donate the money they spent on cigarettes to organizations working against AIDS we could really turn this terrible epidemic to improve the public's health.

Finally, we must keep our eye on the ball, which is to prevent infection with this virus. To do so, we must distinguish the *beef,* as in "Where's the beef?", from the *baloney,* as in, for example, the recent story which originated in this city, again exhorting people to the supposed dangers of mosquito-borne transmission of AIDS. There are many other such distractions. Every hour spent focusing on nonsense is an hour not spent dealing with sexual, perinatal, and parental transmission, which is what we need to be concerned about.

If we do what we all need to do in this, then in addition to ridding our communities of AIDS, we will also greatly reduce TV drug abuse, other sexually transmitted diseases, and teenage pregnancy. Then we could indeed rejoice at being free at last.

Testimony of
Dr. Burton J. Lee, III
Member, Presidential Commission
on the HIV Epidemic

to

The U.S. House of Representatives
Select Committee on Narcotics Abuse and Control
and
The Congressional Black Caucus

September 25, 1987

Thank you for allowing me to make this statement before the Select Committee on Drug Abuse as part of the Congressional Black Caucus. I particularly want to thank Congressman Rangel, and Edward H. Jurith, the Select Committee Staff Director, for their invitation to address this Caucus.

AIDS has enormous implications for all of us. It is a problem that has not yet been adequately faced by our government. The budgetary consequences alone of this health crisis should gather the attention of everyone. The indirect costs of AIDS represent 1.2% in 1985 and 2.1% in 1986 of the estimated indirect cost of all illness, and are estimated to rise to almost 12% in 1991. Personal medical care costs may reach ten billion dollars in 1991 and non-personal costs for research, screening and education in general, and support services are estimated to rise to 2.3 billion dollars in 1991. These numbers are probably low. They do not take into account the incalculable spread of the disease into the heterosexual community. They probably underestimate the number of HTLV infected persons. They do not take into account the fact that current drugs which are under testing might greatly prolong the lives of persons with AIDS (PWA's), or rising health care costs which include enormous expenditures to pay for these drugs.

Without question, this disease has disproportionately affected minority populations. Recent figures reveal that 24% of AIDS patients are black and 14% are Hispanic, whereas these groups represent only 12% and 6% respectively of the U.S. population. Blacks and Hispanics also account for 75% of all heterosexual adults with AIDS and 79% of all children with AIDS. This is because of a disproportionate incidence of I.V. drug addiction in the minority populations. The National Institute of Drug Abuse has recently reported that

63% of their patients were black or Hispanic, and that in proportion to their numbers in the population, blacks and Hispanics were 9 and 8 times more likely respectively to be drug abusers than whites. Seventy percent of patients with AIDS in Harlem Hospital have a history of I.V. drug use. As we can see, one of the major outlets of the disease into the heterosexual population is through drug abusers.

A different and probably more profound problem relating to drug abuse is the effect that it has on the social matrix of these minority populations. Seventy percent of the inmates in Rikers Island Prison in New York City are said to have a positive history for I.V. drug abuse. Seventy percent of those inmates in Rikers Island also do not have more than a 6th grade education. These same figures apply to Greenhaven Prison, a maximum security prison in New York state. According to the National Alliance of Business, 23 million adults are functionally illiterate in America today. Another 47 million are borderline illiterates, a total of 70 million, or approximately one-third of our adult population. Yet 50% of all new jobs will require education beyond high school, and 30% will require a college degree. Over one million youths drop out of school each year, and in our inner cities, the dropout rate is close to 50%.

I recently attended an eighth grade graduation ceremony at the Mahalia Jackson Elementary School in Harlem. The theme was "Say Yes to Life," and stressed "Say No to Drugs" and "Say No to Sex." The principal, Mrs. Constance Wingate, addressed the class and said, "You are about to leave this school, but I will always be here for you if you ever need me. Wherever you go, whatever you do, remember that you will always have to answer to me. You are <u>my</u> children, and I care about you." No child, parent, or observer like myself in that auditorium was unmoved by her words. Mrs. Wingate is exactly the kind of model we all need. How can we find more like her?

When we talk about education and solving drug abuse and AIDS problems through educational efforts, we must look at this population that we are trying to educate. Drug addicts and persons who have already refused or been unable to accept available educational opportunities at a grade school level are not easy people to reach. Educational efforts can not wait for high school. They must start much earlier, and much stronger messages must be sent. The family **must** bear responsibility here. Schools are not able to act totally "in loco parentis."

What else are we going to do about this drug problem? Even if methadone were the answer--which it is not--by the time these drug users get to methadone clinics, between 50 and 70% of them in New York State are already HTLV positive. Giving them free methadone and clean needles at this point

may help with their heroin problem, but it certainly does nothing about their AIDS problem.

The social problems of the minority communities are much deeper than can be cured by simple education, have to be addressed in a much more basic fashion. A true "war" must be waged on drug traffic in the fashion that has been described by Mayor Ed Koch. Drugs--and AIDS--are global problems, and demand global as well as local solutions. Part of this war must be against the "demand" side of the equation, i.e. the potential user. This may be the most successful part of the war. There must be censure, loss of status, and punishment, accompanied by an intensive education campaign in our schools. We cannot continue to allow television and Hollywood to glamorize the drug culture at the expense of our youth.

We must develop welfare programs which reward the family where the father is at home, and not the reverse. It is in homes where young males grow up in a fatherless household, often with no job, no future, and no hope, that most of our extraordinarily violent crime is being bred. These are the types of social problems that underlie the rapid spread of the AIDS virus through our minority communities. If we do not address these underlying problems, we will be not addressing the AIDS crisis on its most basic level.

We need more leaders from your community. We need strong leaders with whom these young men can identify and to whom they will listen. They will not listen to me. I have tried. Therefore, I have recommended to the chairman of our Presidential Commission that we appoint four advisory councils to the commission. The first, a Minority Advisory Council, would hopefully be composed of just such a group of leaders to help us bring the message into our minority populations.

The second advisory council would be Congressional. We need strong support from Congress. We need the help of Congressmen from both houses who are particularly interested in this epidemic. We need their proposals regarding upcoming legislation.

The third advisory council would be from the biomedical community and I am recommending that Dr Koop head this council along with Dr. Sam Thier, the president of the National Institute of Medicine. Dr. Fauci from the NIH and Dr. Axelrod, the Commissioner of Health of New York State are also physicians who I hope would serve on this council.

The fourth would be a Media Advisory Council. We need help from the media to educate the people in this country about AIDS, about its mode of transmission, the myths

regarding its modes of transmission, about necessary changes in various types of risk behavior, about the particular dangers of promiscuity. We need their expertise in developing communication networks uniquely tailored to each minority community. We also need their help in promoting the activities of the Presidential Commission instead of continuing this constant critical attack. Let them attack us after we have made our recommendations.

I cannot speak for the Presidential Commission on the HIV epidemic at this point in time, but I can speak for myself, and I want to tell you all that I am totally committed to the task we have before us. The most difficult areas do relate to the rapid spread of disease within minority communities, the massive drug addiction problem and the spread to heterosexuals via drug addicts and the bisexual community, approximately 10% of our population.

As a Presidential Commission, we have been given a mandate to advise the President on national policy issues concerning AIDS. At the top of that list must be discrimination. No one should lose his job or have his house burned down because he is HIV-positive.

Please come to us with your concerns, your ideas, your recommendations. Let us help you implement these recommendations. We are deeply concerned and will be most receptive to any and all input from this Caucus and from members of this Committee. Remember, our final recommendations go directly to the President of the United States.

Thank you for your help.

TESTIMONY OF
MARGARET C. HEAGARTY, M. D.
DIRECTOR OF PEDIATRICS
HARLEM HOSPITAL CENTER
TO
THE CONGRESSIONAL BLACK CAUCUS
SEPTEMBER 25, 1987

I am privileged to have the opportunity to testify before this distinguished Congressional committee about the problems of drug abuse and AIDS as related to minority children.

As the the director of pediatrics of the Harlem Hospital Center, I and my colleagues in the department serve as a major source of medical care for the children of Harlem. Every year we care for about 2000 hospitalized children, 2500 to 3000 newborn infants and provide roughly 60,000 to 70,000 outpatient visits. About 30 fully trained pediatricians and 27 young physicians in training provide this pediatric care.

Harlem is in the midst of an epidemic of a new and terrifying disease of infants and children. Let me give you some idea of what has happened over the past two or three years. Children with AIDS come to us as infants with severe, sometimes rapidly fatal, infections, severe growth failure to the point of emaciation, chronic lung infections, and in late stages of the disease signs of severe neurological deterioration. By 1985, we had identified about 10 such infants and children, of which two or three were hospitalized at any one time. By spring of last year, we had identified 25 or more, and on average had 4 to 6 in the hospital at any one time. By this time we have cared for about 50 or 60 of these children, 8 to 12 are in hospital at any one time. In fact, the total number of children with

this infection for whom we are responsible has tripled over the past year to 18 months.

Who are these children? In Harlem, as in the nation, most children contract the HIV virus from their mothers during pregnancy or during the process of delivery. When the virus is transmitted, during pregnancy or during delivery is uncertain at this time. And most of these infected mothers are either past or present intravenous drug users or have had sexual relations with someone who is infected with the virus, usually an intravenous drug user, or perhaps a bisexual man. The mothers themselves may have no symptoms of the disease and thus be unaware of their infection. In more than one instance, we have made the diagnosis of AIDS in a child of a mother with no symptoms of AIDS, no history of intravenous drug use and no reason to suspect that she had contracted the infection during intercourse with a man who carried the HIV virus.

It is easy, I suppose, to judge, perhaps even condemn these parents, particularly those who are active drug users. But we who care for them and their children have become less punitive in our judgments, for we have come to know them and their children, have come to appreciate the tragedy of their lives, to stand in awe before their grief as they watch their children slowly die of AIDS. I assure you that I do know that some of these parents have a form of social leukemia which, for whatever reason, has lost them to the larger society. And indeed they can be aggravating, hostile, abusive, frustrating people, but they also can be courageous, appreciative, and many, if not most, in their own fashion love their children as you love yours. And so first, and perhaps most important, I plead that

you see these parents and their children as victims, rather than villains of AIDS. In the face of such a frightening disease as AIDS, it is tempting to look for someone or some group to blame, to make the scapegoat, but the fact is that AIDS is a viral infection, which is usually lethal, it is not a sin, it is not a crime committed by people or groups of people against others.

Another malignant virus has recently attacked Harlem, a virus which complicates the already difficult problems for children with AIDS and one with which this committee surely has more expertise than I. In the past year to 18 months we, as all areas of the country, have encountered an enormous increase in cocaine or crack use among young men and women. But consideration of the children of these cocaine addicts has not received nearly as much publicity as other aspects of the so called crack epidemic. The number of newborns and other children with parents who are addicted to crack and who cannot take care of their children has escalated so sharply that New York City's foster care system has been all but overwhelmed. We now have in New York legions of homeless children, most of whom are children of parents who are addicted to cocaine or the older drug, heroin. Since many drug addicts use more than one type of drug, there is an inevitable overlap between crack and heroin users. Hence many of these homeless infants may have been infected with the HIV virus.

Indeed I think that in many ways the cocaine epidemic has caused more damage to the children of Harlem than the AIDS virus. Let me give you two examples. Last year at Harlem Hospital we admitted about 12 or 13 young adolescents with either gunshot or stab wounds, only one of which we knew was drug related. In the first four months of this year we admitted 13 young adolescents, 9 of whom we knew were

drug related. The amount of violence in the adolescent population has escalated sharply in the past 18 months that I sometimes feel as if I am running a MASH unit rather than a pediatric service. Or to give another example, in the past few months we have admitted several small infants with bizarre unexplainable symptoms who on testing were found to have cocaine in their bodies. Our only explanation is that these infants were in rooms in which crack was smoked to a degree that they became toxic by inhaling the smoke, a passive cocaine intoxication.

Since these two epidemics, AIDS and cocaine, have affected the poor more than other groups, they have placed enormous financial stress upon the hospitals that provide care for the poor, specifically public general hospitals like Harlem Hospital Center. Now these hospitals in the best of times are financially fragile because they must rely upon local tax levy funds for survival. The additional burden of these two problems imperils the entire municipal health care system of New York and other cities facing similar problems.

The solutions to these two problems, AIDS and Cocaine, are at best problematic and complicated, but it is clear that considerable additional resources must be devoted if we are to have any influence upon the course of these related epidemics. We know that the HIV virus is commonly transmitted by needle use in the intravenous drug using groups in our society. We know that methadone is a reasonable alternative for intravenous heroin use. Yet the waiting period for enrollment in a drug treatment program is so long as to discourage all but the most determined. I'm told that there is a 2000 person waiting list for drug treatment in New York City. We know that cocaine is destroying the families and children of Harlem, yet our efforts to

curtail this epidemic and to treat those addicted to this drug seems almost negligent and uncaring in its scope and intensity.

Now to my naive mind, it seems reasonable to consider the AIDS and the cocaine epidemics analogous to natural disasters. When a flood or hurricane or tornado occurs in this country, the central government, acting for the entire body politic, declares the region a disaster area and provides funds to help the area recover. I can't help wondering why the federal government doesn't consider these epidemics, disasters, and declare the areas of this country in which they have reached epidemic proportions, medical disaster areas to which national funds should be allocated on an emergency basis.

Our existing public human service programs were designed in categories that are no longer valid or useful for these as well as other diseases and conditions. Their statutory and regulatory requirements are so complex, dysfunctional, fragmented and disorganized that my professional staff often spends as much or more time dealing with a variety of local, state and federal governmental bureaucracies as they do providing direct care and support for children and their families. In our zeal to make absolutely certain that no rascals, no scoundrels get something to which we judge they are not entitled, we have constructed paper edifices and barriers that only the most socially organized and educated can master. And we wonder why the most socially disorganized and disadvantaged of our communities have trouble "getting on Medicaid" or registering for this or that program. Indeed we sometimes blame them, call them unmotivated, non compliant, or worse. Let me suggest that you or I would have similar problems if we suddenly had to enroll in Medicaid, welfare or SSI. Indeed I, myself, have an acute anxiety attack when I

have to face the Bureau of Motor Vehicles for a driver's license, I suspect I would decompensate entirely if I were a drug using patient with AIDS and had to manage to qualify for Medicaid or SSI.

I tell you that these two things, cocaine and AIDS are wrecking an entire generation of children in Harlem. I despair for the lost generation of adolescents I met on my wards who are addicted to cocaine. As we treat their wounds sustained from the cocaine battles of the street, I recognize that they may very well be doomed unless we find help for them soon. And I know for certain that the children with AIDS are doomed, and I can only hope that we as a society will act to try to prevent other children from the slow, premature death of AIDS. We, all of us, must be prepared to mobilize the resources of this nation in this battle, for history will surely judge us by our actions in this social and human crisis.

Department of Justice

STATEMENT

OF

J. MICHAEL QUINLAN

BEFORE

THE

SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL
OF THE
U.S. HOUSE OF REPRESENTATIVES

CONCERNING

Drug Abuse and AIDS Within the
Federal Inmate Population

SEPTEMBER 25, 1987

Mr. Chairman and Members of the Select Committee:

I appreciate this opportunity to testify about my concerns regarding AIDS and drug abuse among inmates confined in the Federal Bureau of Prisons.

INTRODUCTION

As you know, the President issued an Executive Order in June recommending the testing of Federal inmates for the occurrence of HIV infection. Attorney General Meese directed the Bureau of Prisons to develop an HIV testing program that would address two major unknowns: What is the prevalence of HIV infection in Federal prisoners and what are the risks of acquiring the HIV infection in our prison environment?

On June 15, 1987, the Bureau of Prisons began testing for HIV infection in two large groups of inmates: all newly sentenced prisoners, and all inmates within the sixty days before their release. As part of the testing, the group of newly sentenced inmates will be retested in three months, in six months, and every six months thereafter. Results from the retesting will give us information about the risk of acquiring the infection during confinement.

The Bureau of Prisons has adopted the classification system developed by the Centers for Disease Control for defining different stages of the HIV disease process. We monitor all inmates who have been identified as being at any stage of the disease and attempt to insure their anonymity. For the purpose of this testimony, we can classify three stages of the disease. End-stage AIDS is the most advanced form of the disease. An intermediate stage includes inmates with symptoms less severe, but often requiring intermittent hospitalization. The first stage, consisting of HIV positive inmates, are those who tested positive for the antibody but have no symptoms.

Out of a total inmate population of 44,000, we currently have 33 inmates with end-stage AIDS. Our AIDS policy consists of treating these inmates at one of our medical centers where they can be closely monitored and treated. Many of the patients who are at an intermediate stage of the disease are also in one of our hospitals for treatment until their clinical condition improves. Inmates who have milder symptoms are treated at their local institutions and remain in the population.

Inmates who have tested positive for the HIV antibody but have no disease symptoms are "mainstreamed" by continuing them in the normal prison environment; however, only medical personnel and other key personnel are made aware of positive results on a "need to know" basis.

The Centers for Disease Control has indicated that there is no evidence of transmission of the disease by casual contact. We have established a major education program for inmates and staff based on what is known about AIDS. We believe education to be the most important step to be taken in the attempts to contain the effects of this disease. All staff and inmates are required to view an AIDS training film. The film stresses basic information about AIDS and emphasizes that the disease is transmitted by sexual activity and intravenous drug use with contaminated needles.

We are currently reassessing the issue of staff and inmate safety in view of the consequences of infection from AIDS. Those inmates who are infected but are asymptomatic present the most troublesome problem. We are especially concerned about the inmate who is infected and whose behavior imposes a risk to other inmates and staff. Infected inmates who are sexually active homosexuals or intravenous drug users may require separation from the regular inmate population. On those occasions where staff must use force to subdue a violent inmate, extra precautions are taken to prevent accidental infection.

DRUG ABUSE AND AIDS

Mr. Chairman, I would like to turn my attention to drug abuse among inmates, and especially its relationship to AIDS. As you know, intravenous drug use with shared needles is a major source

of infection for AIDS. Among newly committed inmates, this appears to be a far more common source of infection than homosexual contacts. Because of this well-documented relationship, we must be constantly vigilant for the occurrence of intravenous drug use among inmates. We also have a responsibility to offer former intravenous drug users (as well as any drug user) counselling and drug treatment programs.

As part of our policy of detection and prevention of drug use among prisoners, we conduct random drug tests on suspected users, as well as on a group of randomly selected inmates. The tests detect barbiturates, cocaine, opiates, amphetamines, THC, and other drugs. We also test all inmates who return from community furloughs. We conducted 45,751 tests in 1985, 52,733 tests in 1986 and through the third quarter of this fiscal year, 44,886 tests. The percentage of inmates testing positive for drug use in these years was 7.43%, 4.45% and 3.6%, respectively. Among those who tested positive in the current fiscal year, 56.6 percent were for THC (marijuana), 16.5 percent were for cocaine, 15.8 percent were for opiates, and 18.5 percent were for amphetamines, barbiturates and other drugs.

The Bureau of Prisons' efforts at curbing the illicit use of drugs within prison has shown significant progress in the last two years, as can be seen from these testing figures. Based on the drug testing results, it is difficult to surmise the extent of intravenous drug abuse. Although we know a small

fraction of our inmates sometimes use opiates and other potentially injected drugs, we do not know the exact method by which they take these drugs. We believe it is difficult for most intravenous users to continuously evade both the drug testing and the random searches of their living areas for drug paraphernalia and other contraband. However, because this surveillance program is not complete, it is also important to educate inmates about the extreme dangers of acquiring an HIV infection.

Every inmate who enters prison with a history of drug use is interviewed and evaluated by a psychologist. All inmates with a prior history of drug abuse are offered the opportunity to participate in a chemical abuse treatment program. It is very difficult to prevent an inmate from resuming a pattern of drug use upon release and it is our contention that post release aftercare is equal to, or perhaps more important than, the therapy and education an inmate receives in prison.

AIDS, DRUG ABUSE AND MINORITIES

Mr. Chairman, I know you are deeply concerned about the effect of drug abuse and AIDS in the minority community. I would like to turn my attention to some of those issues as they relate to the Federal inmate population. Blacks and Hispanics comprise 51 percent of the current Bureau of Prisons population. Of the

federal inmates who have been identified as having some stage of the HIV disease, 78.3 percent are black or Hispanic.

As reported in the August 17, 1987 issue of "U.S. News and World Report," minorities make up less than one fifth of this nation's population, and represent over 40 percent of the 38,000 AIDS victims. Among Federal inmates, we find that minorities comprise 82 percent of AIDS patients, 83 percent of the inmates in an intermediate stage of the disease and 74 percent of the inmates who test positive for the disease but who have no symptoms.

Through counselling and interviews, we try to determine the most likely behavior which placed the AIDS infected offenders at risk prior to their incarceration. As you are aware, the dominant risk factor in this country is homosexual behavior followed by intravenous drug use. As indicated earlier, inmates entering the Federal Prison System show a dominant risk factor of intravenous drug use (75 percent) followed secondly by homosexual behavior (9 percent). The other 16 percent consists of a mixture of bisexuals, heterosexuals, prostitutes, those with a history of multiple sex partners, hemophiliacs, and those infected through blood transfusions. This proportion holds for minorities as well as the white infected population.

AIDS TRENDS AND COSTS

Mr. Chairman, I would be remiss in this discussion of AIDS and drug abuse if I did not address the issue of costs. If we

continue to test every admission and releasee and to perform follow-up tests on inmates with negative test results, the testing alone will cost $300,000 a year. The cost of treatment for AIDS patients with opportunistic infections such as forms of cancer and pneumonia ranges from $50,000 to $120,000 per case. We are providing the experimental drug AZT for those inmates for whom it is indicated and those who can tolerate its side effects. The cost of this treatment alone is $8,250 per patient per year. Although the current caseload of end-stage AIDS patients is low (33 inmates), it is likely we will see an increase in this caseload over time. Complicating this projection, Mr. Chairman, is the potential impact of the 1986 Anti-Drug Abuse Act and the impact of sentencing guidelines to be implemented in November of this year. The legislation will increase our drug offender population and the guidelines may increase the number of prisoners and the length of their incarceration.

As I am sure you appreciate, Mr. Chairman, the two most compelling problems facing the Bureau of Prisons in the next several years are the impact of population increases on an already strained system and the alarming potential for increase of HIV infection. We have tried to anticipate this challenge by a comprehensive program that monitors the incidence of the infection and its spread. Education and counselling programs are essential. We are also constantly reassessing our policy in light of new information about the disease and its prevalence in our population.

That concludes my formal statement, Mr. Chairman. I would be pleased to answer any questions you or your colleagues may have.

American Correctional Association

4321 Hartwick Rd.
College Park, MD 20740
(301) 699-7600

STATEMENT OF

ANTHONY P. TRAVISONO
EXECUTIVE DIRECTOR
AMERICAN CORRECTIONAL ASSOCIATION

BEFORE THE

SELECT COMMITTEE ON NARCOTICS
ABUSE AND CONTROL

U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 25, 1987

Mr. Chairman and distinguished members of the Committee, thank you for inviting the American Correctional Association (ACA) to discuss the topic of AIDS--Acquired Immunodeficiency Syndrome as it relates to intravenous drug abuse.

Let me begin by providing some background on the ACA. The ACA was formed in 1870 as an outgrowth of the American Prison Association. The purpose over the years has been to provide professional identification on a national level for those correctional workers nationally and internationally. Currently the ACA membership stands at more than 23,000 individuals in all components of adult and juvenile corrections. In our organization, corrections representation includes federal, state, and local workers in adult and juvenile facilities as well as community corrections including probation, parole, early diversion and pretrial services. Jails and detention facilities also comprise our network of representation. For more than a century, the ACA has worked toward a unified voice in correctional policies and goals. The ACA has been involved in continuing to develop a national correctional philosophy; in designing and implementing standards for correctional services and methods for measuring compliance; in conducting workshops that explore the latest problems and issues in the field and offer professional growth. The ACA publishes a great deal of professional information through its newsletters, magazine and books, and provides training and technical assistance.

There is growing nationwide concern among correctional professionals and federal, state, and local criminal justice officials regarding a proper criminal justice response to the extremely complex problem of AIDS. Reactions and techniques that develop in the public sector toward AIDS may not necessarily be the best responses for corrections to follow.

As recently as last week the nation's correctional chief executive officers met in Denver to discuss a number of concerns, including the growing phenomenon of AIDS, but the discussion did not lead to a consensus on how best to handle the problem within correctional institutions. One of the most hotly debated topics concerned mass screening or testing. Correctional professionals at this time do not see a correctional reason for mass testing; however, they are aware that there may be a political response or maybe even a public health response that is necessary.

At this very hour, about 50 sheriffs, correctional leaders and federal government officials from around Washington, D.C. are discussing the problem of AIDS at an ACA-sponsored meeting in College Park. The ACA is aware that new information is being generated by the Centers for Disease Control (CDC) in Atlanta and other medical groups quite rapidly. Because of this, we have called our colleagues together today to discuss the issues and search for unanimity in policy and procedures. While solutions may not be available, useful information will be exchanged. We will be happy, Mr. Chairman, to send to you and the Committee the results of today's meeting.

Although the ACA does not have a firm policy statement regarding AIDS, we began developing policy guidelines on AIDS in early 1985 with the significant help of three federal agencies: the Centers for Disease Control (CDC), the National Institute of Justice (NIJ), and the National Institute of Corrections (NIC). Several meetings sponsored by NIC were held nationwide, and two national surveys were conducted by NIJ and ACA to determine the extent of the AIDS problem in both correctional institutions and our nation's largest jails. NIJ published the results of those surveys; the first edition in April 1986 and the second edition in May 1987. A third edition will be published in the spring of 1988. We wish to thank the three federal agencies for their

professional response and their continued partnership in providing information to state and local correctional officials. Without the information, we probably would be significantly out of step on control issues.

Correctional officials throughout the nation now have more than 570,000 men and women in custody in state and federal facilities, and on any given day there are more than 250,000 men and women in our nation's jails and detention centers. However, more than 18 million people are processed through these jails and detention centers each year. These numbers are staggering, and each day a new record for correctional populations is being set.

For the past two years the correctional population has grown by more than 1,000 additional people each week. It is likely that the correctional population will continue its dramatic increase for the next 10 years or so.

Therefore, with the enormous number of persons being incarcerated, correctional officials cannot wait for a final answer on how to deal with AIDS victims. Lives are at stake now for both inmates and correctional officers and families of inmates who may be eventually paroled or complete their sentences. Science cannot produce a quick fix, nor is there a cure around the corner. So the slow and agonizing deaths will continue, and the health threat to other inmates and those who work with them will continue to loom ominously. Therefore, it behooves every federal agency and every correctional agency to be informed with all available information and to be constantly alerted to new options for care and custody of inmates with AIDS.

As a general summary as reported in the NIJ Report , AIDS in Correctional Facilities, Second Edition (May 1987), the following is significant:

> Since the publication of the original report in April 1986, evidence against transmission of the AIDS virus through casual contact has become even more conclusive, but so has evidence of heterosexual transmission. The number of inmate AIDS cases in correctional institutions has increased, although at a slower rate than in the United States at large. The number of

AIDS-related inmate lawsuits against correctional systems has significantly increased. Inmate and staff training on AIDS continue to be widespread, but there is still much room for improvement in format and content. Even fewer correctional systems than last year are screening all inmates for antibodies to the AIDS virus, but more are screening members of risk groups. Finally, fewer correctional systems are segregating inmates with AIDS-Related Complex (ARC) and those who are asymptomatically seropositive.

Incidence of AIDS Among Correctional Inmates

As of October 1, 1986, there had been 1,232 confirmed AIDS cases among inmates in 58 responding federal, state, and local correctional systems. There had been 784 cases in 31 state and federal correctional systems--up 72 percent from the 455 cases reported as of November 1, 1985, the time of the original survey. Twenty-seven responding city and county jail systems reported 448 cases--up 44 percent from the 311 cases reported in the original survey eleven months earlier. Total AIDS cases in all responding correctional systems increased from 766 to 1,232 --or 61 percent--in the eleven-month interval. This is a large increase in cases, but it is, in fact, smaller than the 79 percent national increase from 14,519 cases as of November 4, 1985 to 26,002 as of October 6, 1986.

The figures above are cumulative totals--that is, all cases reported since the correctional systems began keeping records. Twenty-three state and federal systems reported 174 current cases of AIDS among inmates, while six responding city and county systems reported 29 current cases. State and federal systems report that a cumulative total of 463 inmates have died from AIDS while in custody; responding city and county systems report 66 inmate deaths. Of these total inmate AIDS deaths, 254--or 48 percent--have occurred since the 1985 survey was taken.

More correctional systems now appear to be maintaining statistics on ARC than were doing so at the time of the 1985 survey. However, several of the jurisdictions with the largest numbers of AIDS cases still do not maintain figures on ARC. Thus, these statistics are still probably artificially low: 321 current ARC cases in 26 state and federal systems, and 28 current cases in 25 city and county systems.

The distribution of cumulative total AIDS cases across correctional systems is still highly skewed (Appendix A). While 10 more systems than last year reported at least one case, the majority (35 of 51 state and federal systems--or 68 percent--and 18 of 33 city and county systems--or 54 percent) still have had fewer than four cases. At the other extreme, only three state and federal systems and one responding city or county system have had more than 50 cases. Three state systems (6 percent) account for 74 percent of the cumulative total AIDS cases, while

two of the responding city and county systems (6 percent) contribute 73 percent of the cases.

The Middle Atlantic states still account for the vast majority of AIDS cases among correctional inmates (Appendix B). Seventy-one percent of state systems' cases and 68 percent of cases in responding city and county systems have been in the Middle Atlantic region. However, it should be noted that correctional AIDS cases have increased in all regions since the original survey was taken. More and more correctional systems are likely to experience AIDS cases each year, although the overall distribution of cases will probably remain highly skewed across correctional systems and geographic regions.

The incidence rate of AIDS in the United States was 5.3 cases per 100,000 population in 1986, up from 3.4 in 1985. Incidence rates for individual states range from 0 to 21, with most under 3. In state and federal correctional systems incidence rates ranged from 5 to 215 per 100,000, although two-thirds of the states have rates less than 25 and only three have rates over 100. Rates in city and county jail systems vary from 15 to 148 cases per 100,000, although rapid jail population turnover makes these statistics extremely suspect.

Incidence rates are predictably higher in correctional systems than in the population at large because of the concentration in inmate populations of persons with demographic, racial/ethnic and behavioral characteristics closely associated with AIDS--young adult males; Hispanics and blacks; and intravenous drug abusers. Moreover, the method of calculating incidence rates per 100,000 population guarantees that a correctional system with a very small number of AIDS cases--the typical case--will have a somewhat higher rate than a much larger outside population with substantially more AIDS cases.

The wide range in incidence rates obviously reflects the uneven distribution of AIDS cases across correctional systems. The jurisdictions with the highest incidence rates continue to be in the Middle Atlantic region, where HIV infection is pervasive among intravenous drug users who are drastically over-represented in corrections institutions.

Characteristics of Inmate AIDS Cases

Though data on the characteristics of correctional AIDS cases are limited, a study of 177 inmate deaths from AIDS in the New York State correctional system reveals some striking demographic information. Ninety-seven percent were males, and 76 percent were between 25 and 39 years old. Fully 92 percent of these inmates admitted to intravenous drug abuse, 40 percent were Hispanic, 39 percent were black, and 86 percent came from New York City.

Transmission of HIV Infection in Correctional Institutions

The extent to which HIV infection is transmitted within correctional institutions remains a controversial subject. The few systematic studies done suggest that transmission in prisons and jails has occurred infrequently. The Maryland study discussed in the 1985 report discovered a seropositivity rate of 1.5 percent among long-term inmates who volunteered to be tested. Seropositivity in an inmate continuously incarcerated for 7 years or more (i.e., since before the AIDS virus appeared in the United States) was assumed to mean that seroconversion occurred during incarceration.

New York State recently analyzed the periods of continuous incarceration of all of its correctional inmates with AIDS. The analysis revealed that none of the inmates had been continuously incarcerated for more than 7 years prior to their diagnosis, and only 5 inmates (2.3 percent) had been continuously incarcerated for 5-7 years prior to their diagnosis.

These figures also suggest low rates of transmission. However, as the New York report notes, "the long incubation period, the existence of the asymptomatic HIV carrier state, small number of long-term inmates and absence of data on antibody status make this finding inconclusive." Firmer conclusions on HIV transmission in correctional facilities await systematic followup studies. At this writing, CDC is planning to sponsor such studies in several correctional systems.

AIDS Cases Among Correctional Staff

As with the original survey, the 1986 survey identified no cases of AIDS among correctional staff attributable to contact with inmates.

Although our 1986 figures indicated that the number of states using mass screening has decreased from four states to three, several states and systems have either legislated mass screening or ordered that AIDS screening be handled under the catagory of communicable disease.

Correctional professionals do not have a problem in deciding what to do with inmates who have AIDS and cannot function in the open environment of a correctional unit--they are either hospitalized within the institution or in a community hospital. The problem is what to do with those who test positive or have AIDS-Related Complex (ARC). We recently learned that the State of California Department of Corrections is beginning to separate those inmates

who test positive. They are currently using separate wings of the Vacaville medical facility.

Mr. Chairman, we are aware that your interest and that of the Narcotics Abuse and Control Select Committee is concerned with the implications of intravenous drug abuse and the subsequent condition of AIDS. Believe me, the entire criminal justice system is also alarmed at the implications as they present themselves to police, courts, and corrections. For whatever reasons, there are more AIDS victims in correctional institutions attributable to intravenous drug abuse through dirty needles than attributable to homosexual contact within the community or in correctional institutions.

Since an extremely high number of inmates use a variety of illegal drugs, the number of incarcerated intravenous drug abusers will probably continue to increase significantly over the next several years, provided there is continued pressure to get drug abusers off the streets.

There is an indication in a federal government study, yet to be released, that in New York City alone at least 2,000 arrested intravenous drug abusers per month will be seropositive. If this number continues, the consequences for the criminal justice system will be overwhelming.

On Monday I discussed the AIDS situation in the New York State Department of Corrections with Commissioner Tom Coughlin. The New York Department of Corrections has had 370 confirmed AIDS cases since they began counting, and all but one of the cases have been the result of intravenous drug use; the one was a combination of homosexuality and intravenous drug use. The great majority of persons with AIDS in the New York system today are from the Hispanic community. Commissioner Coughlin and the Department are still not planning to conduct mass testing of all inmates on a regular basis. However, beginning this month there will be a double-blind study conducted by the

Department of Corrections and the Department of Health for the next 2,000 new inmates to determine the incidence rate.

A drug prevention program of mass proportions must be established as soon as possible to decrease the number of cases that loom on the horizon. With no cure in sight, the prospect exists that correctional officials may be called upon to operate hospices rather than correctional institutions.

From each component of the criminal justice system there are enormous legal, medical, and, of course, political questions to be asked and proper answers to be sought. Let me highlight a few:

Police ask:

- Should there be mandatory testing of all arrestees suspected of AIDS?
- Should prosecutors be encouraged to seek maximum sentences for prostitutes with the AIDS virus?
- Should police handle every arrestee as if they had AIDS?
- What are the limits of police liability?
- How much education is necessary to prepare police officers?

Judges ask:

- Should all prostitutes who have AIDS or AIDS antibodies be imprisoned?
- Should longer sentences be given to defendants with AIDS?
- Should presentence reports require AIDS testing?

Probation agencies ask:

- Should probation officers maintain a screening program as part of supervision--should the results be confidential?
- Should a judge use probation for those who are infected?
- Should a judge send a convicted felon to prison because he/she has AIDS?

Prison Officials ask:

- Should they separate those inmates with AIDS antibodies?

- Should there be separate institutions for those inmates?
- Should men and women who work with AIDS patients be paid a premium?
- What kinds of persons do we recruit to do these jobs if, in fact, separation is mandated?
- Should a correctional staff be told of the results of AIDS testing?
- What are the legal liabilities?

Parole officials ask:

- Should parole boards delay release for those with AIDS antibodies or those who have AIDS?
- What level of confidentiality should be maintained? Should families, employers, or others in the community, such as medical authorities, be told of inmates who have AIDS antibodies?
- Should certain conditions be imposed on parolees with AIDS?

These are but a few of the enormously complex questions that criminal justice officials have and will be seeking answers for over the next several years.

Conclusion

Mr. Chairman, even though it appears that in correctional institutions the growth rate in the number of persons who have AIDS-related conditions is slower than that of the general public, the policies that are adopted by the public can have significant effects on corrections: Correctional agencies could be thrust into expensive screening programs that are not needed; eventually corrections might be used as a warehouse for AIDS victims. We suggest that the following ideas be given top priority by Congress and the administration.

1. Continue to appropriate significant funds to stop the use of illegal drugs in our society.
2. Continue to support education and awareness programs to help drug users come to terms with their plight.
3. Continue to support drug abuse treatment centers.
4. Help correctional agencies throughout the United States with the

enormous medical bills for testing and treating of inmates who have AIDS and require hospitalization. The American Correctional Association suggests that the cost of care should be borne by society as a whole through Medicaid funds. The current law forbids Medicaid funds to be used for any inmate in a correctional institution. We now believe the law should be amended to allow funds to be available for the care of AIDS victims.

The correctional community is quite concerned about its responsibility to public health. Some of the questions raised are so significant that it has been extremely difficult for correctional officials to find the proper answers. The ACA-sponsored meeting that is being held today in College Park is a step in that direction, Further, the ACA is in the process of establishing an AIDS task force to see if we can find the answers to some of these questions. We invite you to join with us in this effort.

I again thank the Committee for conducting this hearing and for allowing the American Correctional Association the opportuinity to offer comments on the impact of AIDS in corrections.

APPENDIX A

DISTRIBUTION OF CONFIRMED AIDS CASES AMONG INMATES, BY TYPE OF SYSTEM

Range of Total AIDS Cases	State/Federal Prison Systems							
	Original Survey: November 1985				Update Survey: October 1986			
	n systems	%	n cases	%	n systems	%	n cases	%
0	26	51%	0	0%	20	39%	0	0%
1-3	15	29	24	5	15	29	22	3
4-10	5	10	30	7	9	18	56	7
11-25	2	4	42	9	1	2	23	3
26-50	1	2	33	7	3	6	101	13
51-100	1	2	95	21	1	2	57	7
> 100	1	2	231	51	2	4	525	67
Total	51	100%	455	100%	51	100%	784	100%

Range of Total AIDS Cases	City/County Jail Systems							
	Original Survey: November 1985				Update Survey: October 1986			
	n systems	%	n cases	%	n systems	%	n cases	%
0	13	39%	0	0%	6	18%	0	0%
1-3	10	30	16	5	12	36	24	5
4-10	7	21	43	14	10[a]	30	60	13
11-25	1	3	12	4	3	9	39	9
26-50	1	3	40	13	1	3	40	9
51-100	0	0	0	0	0	0	0	0
> 100	1	3	200	64	1	3	285	64
Total	33	99%[b]	311	100%	33	99%[b]	448	100%

Source: NIJ/ACA Questionnaire Responses.

[a]Two systems in this category at the time of the original study failed to respond to the 1986 survey. Therefore, the numbers reported are from the 1985 survey.

[b]Due to rounding.

APPENDIX B

REGIONAL DISTRIBUTION OF TOTAL AIDS CASES BY TYPE OF SYSTEM (Federal Bureau of Prisons Excluded)

	State Prison Systems			
	Original Survey: November 1985		Update Survey: October 1986	
Region	n Cases	% of Total	n Cases	% of Total
New England[a]	16	3.7%	34	4.6%
Mid-Atlantic[b]	327	75.5	531	71.3
E.N. Central[c]	6	1.4	19	2.6
W.N. Central[d]	0	0.0	1	0.1
S. Atlantic[e]	49	11.3	88	11.8
E.S. Central[f]	1	0.2	5	0.7
W.S. Central[g]	12	2.8	28	3.8
Mountain[h]	2	0.5	2	0.3
Pacific[i]	20	4.6	37	5.0
Total	433	100.0%	745	100.2%[k]

	City/County Jail Systems			
	Original Survey: November 1985		Update Survey: October 1986	
Region	n Cases	% of Total	n Cases	% of Total
New England[a]	0	0.0%	0	0.0%
Mid-Atlantic[b]	222	71.4	307[j]	68.5
E.N. Central[c]	8	2.6	17	3.8
W.N. Central[d]	1	0.3	2	0.4
S. Atlantic[e]	24	7.7	27[j]	6.0
E.S. Central[f]	0	0.0	0	0.0
W.S. Central[g]	3	1.0	6	1.3
Mountain[h]	1	0.3	6	1.3
Pacific[i]	52	16.7	83	18.5
Total	311	100.0%	448	99.8%[k]

[a]Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut

[b]New York, New Jersey, Pennsylvania

[c]Ohio, Indiana, Illinois, Michigan, Wisconsin

[d]Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas

[e]Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida

[f]Kentucky, Tennessee, Alabama, Mississippi

[g]Arkansas, Louisiana, Oklahoma, Texas

[h]Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada

[i]Washington, Oregon, California, Alaska, Hawaii

[j]One system in this region failed to submit a follow-up questionnaire. We used the numbers reported on the original questionnaire.

[k]Due to rounding

TESTIMONY: THE AIDS EPIDEMIC AND DRUG ABUSE TREATMENT

LAWRENCE S. BROWN, JR., MD, MPH

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

SEPTEMBER 25, 1987

MR. CHAIRMAN, I WANT TO OFFER MY SINCEREST GRATITUDE FOR THE OPPORTUNITY TO DISCUSS WITH YOU AND THE OTHER MEMBERS OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL A PHENOMENON THAT GREATLY THREATENS THE VERY FABRIC OF THE BLACK COMMUNITY. I SERVE AS THE VICE PRESIDENT FOR RESEARCH AND MEDICAL AFFAIRS OF THE ADDICTION RESEARCH AND TREATMENT CORPORATION (ARTC), AN ORGANIZATION THAT HAS PRIDED ITSELF IN SERVING THE HARD-CORE, LOWER SOCIOECONOMIC, AND PREDOMINATELY BLACK AND HISPANIC ADDICTED SINCE 1969. AS A NOT-FOR-PROFIT, MINORITY OPERATED ORGANIZATION, ARTC HAS PROVIDED A WIDE RANGE OF COMPREHENSIVE HEALTH CARE AND TREATMENT SERVICES TO WELL OVER 20,000 PATIENTS SINCE ITS FOUNDING. THE AIDS EPIDEMIC HAS HAD ASTOUNDING EFFECTS ON THE HEALTH CARE AND SOCIAL WELL-BEING OF THE PATIENTS, THE RECRUITMENT AND EFFICACY OF TREATMENT STAFF AND THE RESOURCES IN THE URBAN CENTERS IN WHICH THESE FACILITIES RESIDE AND IN WHICH DRUG ABUSE PROMULGATES.

GIVEN THAT INTRAVENOUS DRUG USE REPRESENTS THE SECOND LARGEST TRANSMISSION CATEGORY FOR THE DEVELOPMENT OF AIDS, IT IS NOT SURPRISING THAT INTRAVENOUS DRUG USERS WOULD ALSO DEVELOPE A GREATER PREVALENCE OF AIDS-RELATED DISORDERS. IN MANY CASES THIS HAS RESULTED IN FURTHER STIGMATIZATION BY THE GENERAL PUBLIC, TRADITIONAL SOCIAL SERVICE AGENCIES, SOME HOSPITALS, AND EVEN SOME DRUG TREATMENT PROGRAMS. I HAVE PERSONALLY HAD COMPLAINTS FROM SOME PATIENTS WHO CLAIM THAT CERTAIN RESIDENTIAL PROGRAMS, THERAPEUTIC COMMUNITIES, REQUIRE THEM TO BE TESTED FOR THE HIV OR AIDS VIRUS AND ONCE THEY TEST POSITIVE THEY ARE DENIED ADMISSION. AT A TIME WHEN DRUG TREATMENT REPRESENTS A POTENTIAL MODALITY TO REMOVE THESE PEOPLE FROM THE POOL OF INFECTIVITY, THIS REPRESENTS AN ATROCITY. THAT DRUG TREATMENT ENROLLMENT TRULY REPRESENTS THIS POTENTIAL HAS BEEN DEMONSTRATED IN A COLLABORATIVE STUDY BETWEEN ARTC AND THE ADDICTION RESEARCH CENTER/NATIONAL INSTITUTE ON DRUG ABUSE. OF THE NEARLY 500 PATIENTS WHO PARTICIPATED AND RECEIVED EXTENSIVE PRE-TEST AND POST-TEST COUNSELING, THOSE PERSONS WHO TESTED POSITIVE FOR THE VIRUS HAD A STATISTICALLY SIGNIFICANT SHORTER ENROLLMENT IN OUR PROGRAM THAN THOSE WHO TESTED NEGATIVE. WHILE THIS FINDING MAY BE SUGGESTIVE OF A POSITIVE ROLE OF TREATMENT, ONE CAN NOT CONCLUDE THAT BY JUST OPENING MORE POSITIONS, OUR PROBLEMS WITH AIDS ARE RESOLVED. IN THE AIDS EPIDEMIC ERA, QUALITY IS EQUALLY IMPORTANT. FOR AN EXAMPLE OF THIS, ONE NEED BUT LOOK TO NEW YORK AND THE RESPONSE OF ITS SINGLE STATE AGENCY. WHILE THIS AGENCY AGGRESSIVELY ENCOURAGED TREATMENT PROGRAMS WITHIN THE STATE TO EXPAND, IT DID LITTLE TO PROVIDE A PROPORTIONATE RESOURCES FOR THE WIDE ARRAY OF MEDICAL AND PSYCHOSOCIAL ASSOCIATED

WITH THE HIV-INFECTED INTRAVENOUS DRUG ABUSER. THE PROBLEMS OF THE DRUG ADDICTED SUFFERING FROM AIDS OR A RELATED DISORDER IS MANY TIMES THOSE OF THE NON-INFECTED. IT HAS ALWAYS AMAZED ME, A HEALTH PRACTITIONER, WHY OUR HEALTH CARE SYSTEM IS NOT RECEPTIVE TO IMPROVE THE LEVEL OF PRIMARY MEDICAL CARE IN DRUG TREATMENT PROGRAMS, AT LEAST AS A MEANS OF EARLY RECOGNITION OF HIV-RELATED CONSEQUENCES (AND HOPEFULLY EARLY INTERVENTION), BUT IS WILLING TO INVEST IN EXPENSIVE TERTIARY CARE INSTRUMENTS, THAT ARE EITHER NOT AVAILABLE FOR THIS POPULATION OR OF LITTLE UTILITY BY THE TIME DRUG ABUSERS PRESENT THEMSELVES FOR HOSPITALIZATION. LET ME MAKE IT ABUNDANTLY CLEAR. I AM NOT AGAINST HIGHLY TECHNOLOGICAL HEALTH CARE. QUITE THE CONTRARY, AS THE ATTENDING PHYSICIAN ON ONE OF THE MEDICAL WARDS OF HARLEM HOSPITAL THIS MONTH, I COMPLAIN BITTERLY ABOUT THE LIMITED AVAILABILITY OF INTENSIVE CARE UNIT BEDS, RESULTING IN THE MANAGEMENT OF PATIENTS REQUIRING RESPIRATORY SUPPORT ON UNDERSTAFFED GENERAL MEDICAL WARDS. ONE THIRD OF MY THIRTY-FIVE PATIENTS ARE HOSPITALIZED DUE TO AIDS RELATED DISORDERS AND NEARLY ALL OF THOSE WITH AIDS RELATED ILLNESSES HAVE HISTORIES OF INTRAVENOUS DRUG USE. YET, AGAIN THIS APPEARS TO BE THE LEGACY OF THE TREATMENT OF THE ADDICTED.

UNLIKE THE LARGEST TRANSMISSION GROUP OF HOMOSEXUAL/BISEXUAL MEN, INTRAVENOUS DRUG USERS TEND TO DISPROPORTIONATELY RESIDE IN THE LOWER RUNGS OF THE SOCIOECONOMIC LADDER, TEND TO BE GEOGRAPHICALLY STABLE, AND DO NOT HAVE ANY VOCAL LOBBY IN CONGRESS OR FOR THAT MATTER ANYWHERE IN SOCIETY, THAT AGGRESSIVELY ARTICULATES THEIR CONCERNS. THUS, OTHER THAN DRUG TREATMENT PROGRAMS, THERE ARE FEW PLACES, OFF

THE STREETS OF OUR INNER CITIES, WHERE DRUG ABUSERS ARE WELCOMED. WHILE MANY OF THE AIDS RELATED DISORDERS, SUCH AS ARC OR AIDS-RELATED COMPLEX OFTEN RECEIVED LESSER LEVELS OF ATTENTION IN THE LAY PRESS, THE RECENT AUGUST 14, 1987 REVISION OF THE SURVEILLANCE DEFINITION OF AIDS BY THE CENTERS FOR DISEASE CONTROL, MAY RESULT IN A RE-CLASSIFICATION OF THE PREVIOUS ARC CASES TO AIDS. THE RESULT MAY BE AN SIGNIFICANT RISE IN AIDS CASES, LARGELY DUE TO THE DEFINITION REVISION ARTIFACT. WHILE THIS REVISION WILL ALLOW A GREATER NUMBER OF THE HIV-INFECTED TO RECEIVE A GREATER LEVEL OF SOCIAL SERVICES, BECAUSE THEY NOW MEET THE DEFINITION AIDS, IT ALSO OFFERS THE POTENTIAL FOR A GREATER NUMBER OF DRUG ABUSERS TO BE STIGMATIZED.

FROM THE STANDPOINT OF THE TREATMENT PROGRAMS, THERE ARE MONUMENTAL NEEDS THAT WOEFULLY REQUIRE SATISFACTION. MANY PROGRAMS ARE UNDERSTAFFED AND UNAWARE OF THE LIMITED RESOURCES AVAILABLE TO MEET THE SOCIAL, ECONOMIC, AND LEGAL NEEDS OF THE AIDS PATIENT. RECRUITMENT OF QUALIFIED MEDICAL AND SOCIAL SERVICE STAFF IS DIFFICULT AND RETENTION OF QUALIFIED STAFF IS EQUALLY FORMIDABLE, GIVEN THE HIGH LEVEL OF STRESS ASSOCIATED WITH THESE OF AIDS AND HIV VIRUS ISSUES. ANXIETY LEVELS OF THE STAFF IN MANY PROGRAMS ARE EXTREMELY HIGH, OFTEN RESULTING IN UNCONSCIOUS STIGMATIZATION.

FOR THE COMMUNITIES IN WHICH DRUG ABUSE IS PREVALENT, THE TOLL IS EVEN MORE DEVASTATING, PARTICULARLY IN NEW YORK. APPROXIMATELY 34% OF THE TOTAL REPORTED CASES, 44% OF PEDIATRIC CASES, AND 51% OF ADULT FEMALE CASES OF AIDS RESIDE IN NEW YORK STATE, PRINCIPALLY IN NEW

YORK CITY. THE CASE FATALITY RATE IN NEW YORK OF 57% IS ALSO IN EXCESS OF THE NATIONAL AVERAGE. THIS DISPROPORTIONATELY GREATER RISK EXPERIENCED BY NEW YORK IS LARGELY BELIEVED TO BE ATTRIBUTED TO ITS LARGE COMMUNITY OF SUBSTANCE ABUSERS. INDEED, MORE THAN 850,000 PERSONS OR A MOST 6% OF THE STATE's POPULATION ARE HEAVY SUBSTANCE ABUSERS WITH 58,000 OF THESE ESTIMATED TO BE INTRAVENOUS DRUG USERS, WHICH REPRESENTS NEARLY 65% OF THE ESTIMATED 400,000 NATIONWIDE INTRAVENOUS DRUG ABUSERS. THIS APPARENT SIMILARITY IN THE DISTRIBUTION OF AIDS AND SUBSTANCE ABUSE STIMULATES A MYRIAD OF QUESTIONS.

THE SIGNIFICANCE OF INTRAVENOUS DRUG ABUSE IN THE PREVALENCE OF AIDS AND AIDS-RELATED DISORDERS IS PARTICULARLY DEVASTATING AMONG MINORITIES. BETWEEN WHITES AND MINORITY GROUP MEMBERS, THE RACIAL DISTRIBUTION BY RISK BEHAVIOR DIFFERS. AIDS CASES THAT COULD BE TRACED TO HOMOSEXUAL OR BISEXUAL MEN OR TO THE USE OF BLOOD OR BLOOD PRODUCTS WERE MORE LIKELY TO BE WHITE. BLACKS AND HISPANICS DOMINATED IN CASES ASSOCIATED WITH HETEROSEXUAL CONTACTS, WITH NO IDENTIFIABLE MODE OF TRANSMISSION OR IV DRUG ABUSE. IN FACT AS BAKEMAN AND HIS COLLEAGUES AT ATLANTA UNIVERSITY AND MOREHOUSE SCHOOL OF MEDICINE POINT-OUT IN THE SEPTEMBER ISSUE OF THE JOURNAL OF THE NATIONAL MEDICAL ASSOCIATION, THE BEST PREDICTOR OF AIDS AMONG BLACK WOMEN IS THE DISTRIBUTION OF MALE HETEROSEXUAL IVDA CASES. THERE ARE CLEARLY OTHER ISSUES FOR THE COMMUNITIES IN WHICH INTRAVENOUS DRUG USE IS RAMPANT. FOR ONE, AIDS AND INTRAVENOUS DRUG USE STRIKES DURING A HIGHLY PRODUCTIVE PERIOD OF LIFE. THIS HAS TO OFFER A

SERIOUS HANDICAP IN THE ECONOMIC BASE OF THESE COMMUNITIES. WHILE EPIDEMIOLOGIC EVIDENCE HAS NOT SHOWN THAT HIV INFECTION CAN BE CASUALLY ACQUIRED, ONE HIV-RELATED DISORDER, TUBERCULOSIS IS RISING RAPIDLY IN INNER CITY AREAS WHERE DRUG USE AND AIDS ARE PREVALENT. THIS IS TRULY A DIRECT PUBLIC HEALTH THREAT TO THESES COMMUNITIES. FINALLY, IN COMMUNITIES WHERE SOCIAL SERVICES AND SOURCES OF HEALTH WERE ALREADY PLAGUED BY ISSUES OF INADEQUATE QUALITY AND INACCESSIBILITY, A NEW DEMAND OFFERED BY WHAT WAS TRADITIONALLY A LOW HEALTH CARE UTILIZATION AGE GROUP FURTHER EXHAUSTS THE HEALTH CARE RESOURCES IN THESE COMMUNITIES.

GIVEN THIS LITANY OF PROBLEMS, LET ME OFFER A FEW INGREDIENTS THAT MAY BE USEFUL IN A RATIONALE RESPONSE. FIRST, LET ME SAY THAT DRUG ABUSERS ARE CAPABLE OF CHANGE. BASED ON A NUMBER OF SURVEYS, MANY HAVE RECEIVED THE MESSAGE. A VERY LARGE NUMBER CLAIM THAT THEY NO LONGER SHARE NEEDLES AND A SURPRISING PROPORTION CLAIM TO EVEN USE SOME FORM OF LIQUID TO CLEAN THEIR NEEDLES PRIOR TO USE. THUS, WE SORELY NEED MORE MESSENGERS AND MORE MESSAGES. THE MESSAGES SHOULD BE WELL FOUNDED IN SCIENTIFIC AND EPIDEMIOLOGIC PHENOMENON RELATED TO HIV EXPOSURE OR PROGRESSION AND SHOULD BE CULTURALLY-SENSITIVE. AS FOR THE MESSENGERS, TELEVISION, NEWSPAPERS AND PAMPHLETS ARE INSUFFICIENT VEHICLES OF COMMUNICATION FOR THE DRUG ADDICTED. THERE IS A NEED FOR A CADRE OF FOOT SOLDIERS TO GET OUT AND DELIVER THE WORD. FOR DRUG TREATMENT PROGRAMS TO ATTRACT AND RETAIN INDIVIDUALS IN TREATMENT, THERE IS A CONSIDERABLE NEED FOR AN IMPROVEMENT IN THE QUALITY OF SERVICES. WHEN ONE COMPARES THE EXTERIORS OF DRUG

TREATMENT PROGRAMS IN MANY URBAN SETTINGS WITH THAT OF OTHER TYPES OF HEALTH CARE FACILITIES, IT IS NO WONDER WHY DRUG ABUSERS ARE NOT ENCOURAGED TO ATTEND. FINALLY, THE QUALITY OF PRIMARY MEDICAL SERVICES MUST BE ENHANCED IN DRUG TREATMENT PROGRAMS IF WE ARE SERIOUS ABOUT IMPEDING THE PROGRESSION OF HIV RELATED CONSEQUENCES OR ABOUT EARLY INTERVENTION PRIOR TO GREATER MORBIDITY AND MORTALITY TO THE DRUG USER OR AS IN THE CASE OF TUBERCULOSIS TO THE COMMUNITIES IN WHICH INTRAVENOUS DRUG USE IS ABUNDANT.

AGAIN, MR CHAIRMAN I THANK YOU FOR HAVING PROVIDED ME WITH OPPORTUNITY TO SHARE WITH YOU SOME OF THE THOUGHTS AND CONCERNS OF MY COLLEAGUES AND STAFF ABOUT THEIR ABILITY TO RESPOND TO THIS DEVASTATING EPIDEMIC AND MOST IMPORTANTLY, ABOUT THE SIGNIFICANTLY UNMET NEEDS OF THE DRUG ADDICTED AND OUR COMMUNITIES.

CONGRESSMAN GEORGE HANSEN
[1965-69/1975-85]
400 First Street, N.W.
Suite 809
Washington, D.C. 20001

LEGISLATIVE RECOMMENDATIONS ON AIDS

Former Congressman George Hansen, who spent seven terms in the U.S. House of Representatives and in incarceration in seven federal and state jail and prison facilities during the years 1986 and 1987, provides suggested legislative and regulatory remedies to cope with AIDS in prison. This is a done at the request of Congressional and Executive officials, and prepared especially for Chairman Charles B. Rangel of the House Select Committee on Narcotics Abuse and Control, and also for Dr. Burton Lee, a member of the President's Commission on the H.I.V. Epidemic, who served as a fellow panel member at Congressional hearings held Friday, September 25, 1987.

Legislation or Regulations, as appropriate, should be designed to accomplish the following:

1. Adopt clear and uniform standards and directives to eliminate confusion, fear and tension.

2. Clearly and honestly identify causes of AIDS and how to deal with it; then follow those standards carefully.

3. Require unquestioned caution in all assignments, requirements and activities to reduce tension and potential for violence and riots. Where question exists, lean in favor of caution and away from risk. These procedures should apply to all contagious diseases, without exception, such as:

   A. Precautionary housing and use of facilities.

   B. Non-controversial job assignments.

   C. Proper use of gloves, razors and other hygienic and sanitation consideration.

   D. Sanitizing the quarters of a known victim before the next occupant is housed there.

   E. Requiring open and proper dissemination of inmate health histories to case workers and counselors to enable adequate and fair handling and counseling. People know anyway, either from honesty or from the "pipelines."

   F. Requiring honest progress reports and record keeping. The "lies" now demanded of caseworkers, forcing them to "cover-up" the facts on AIDS and perjure themselves in the process, has caused an open mutiny among some federal prison officials.

(Continued)

4. Require testing of all inmates immediately, and further upon entry, exit and reasonable request. Many circumstances, even beyond homosexual and drug activity, can cause AIDS and this should be clearly recognized. People should not fear that a brief prison stay may well result in the "death sentence" because of failure to practice reasonable precautions. Also, spouses and families, and society in general, should not have to fear the recycling of infected inmates back into the general population.

5. Require proper testing also to more clearly establish the financial liabilities that diseases may hold for both the inmate and the government.

6. Require reasonable "holding" programs to protect the general environment from outside contamination and to end the ugly practice of putting identified victims into cruel disciplinary procedures for isolation such as being tossed into the "hole."

7. Require proper protection of civil rights to assure that victims will be treated kindly as patients, not "punished" as discipline problems. And conversely, assure that people rightfully or wrongfully in the disciplinary process are not crudely exposed to AIDS victims being held in places like the "hole."

8. Require every possible precaution to assign AIDS victims and others with contagious diseases in equal facilities according to their security level. Job assignments should be just as carefully made to reduce, if not eliminate, violence producing factors such as fear and tension.

9. All inmates must operate under the same legal requirements. If heterosexuals are denied conjugal visits, then those practicing "alternative lifestyles" cannot be allowed same-sex "conjugal" activities. The adequate and non-discriminatory enforcement of drug use and sexual practices is fair to all and vital to disease control.

10. Most important of all is to require implementation of an immediate alternative sentencing program to empty the nation's prisons and jails of all possible first-time, non-violent offenders. This is to help eliminate the current dilemma of overcrowded prison facilities, substantially reduce demands on the budget, and, of prime importance, to dramatically diminish the risk of spreading AIDS and the potentially massive financial liabilities it poses for both individuals and the taxpayers. Some states are already successfully employing alternative sentencing. The federal government should be leading the way in such practical solutions, not dragging its feet.

Such solutions must be designed so as to also achieve the following:

1. Upgrade county and other cooperative non-federal facilities

(Continued)

through incentive programs, so as to assure that minimum federal standards will eliminate many of the substandard facilities and "hell holes" yet to be found in the nation's jails.

2. Insist on honest dealing by the federal government in its relationship with non-federal and private facilities to eliminate the personal and financial problems created by instances of deception, such as experienced by local officials at Petersburg when federal authorities passed off an AIDS patient as a routine pneumonia case.

3. Stop treating AIDS as a legal or social disease where people have to admit to "improper" or "illegal" behavior to be adequately tested and treated. We shouldn't treat AIDS with a stigma such as that applied to mental illness a few years ago. AIDS is too deadly to everyone to be a political football. It needs to be out of the closet and openly and effectively dealt with, whatever the cause.

4. Remember the needs of the sick should be adequately treated, without discrimination, but with the special care and consideration their condition requires. The health survival needs of the sick and the healthy can be very different.

5. Upgrade orientation films and memos and regulations, and then back them up with honesty and consistency of action.

6. Discourage the callous and knee-jerk administrative behavior that punishes people seemingly for the sheer sadistic "joy" of it, such as occurred in the bizarre treatment of the father who was put through "hell" in the process of donating a kidney to save his son's life.

7. Eliminate other life and health threatening hazards in federal installations such as clearly identified instances of PCB's, asbestos, toxic chemical dumping in streams, dangerous dust conditions, and use of outdated meat products.

8. Build in every stimulant for openness, even-handedness, and reduction of tension and trauma.

9. Insist that public information officers and other official spokesman deal in truth with the public and the media.

10. Very importantly, give strong consideration to privatizing of prisons to obtain better responsiveness and more protection against budget overrun and financial liability brought on by such unpredictables as the AIDS problem.

Numerous documents and media reports are available to support the need for the legislative and regulatory remedies outlined. this information is from some of the nation's best sources, official and media, and is available upon request.

SUBMISSIONS FOR THE RECORD

U.S. Department of Justice

Federal Bureau of Prisons

Washington, D.C. 20534

November 9, 1987

Honorable Charles B. Rangel
House of Representatives
Washington, D.C. 20515-6425

Dear Congressman Rangel:

This is in response to your October 20, 1987, correspondence requesting follow-up responses to my testimony before your committee's hearing on the impact of drug abuse and AIDS on the minority community.

1. How much does it cost the Bureau to test an inmate? What is the overall cost of AIDS testing in prison?

   An initial average ELISA Test cost is $4.74. This price includes confirmatory second ELISA and Western Blot Tests, if the initial ELISA is positive. The overall cost would be approximately $300,000 a year.

2. To date, how many known cases of AIDS have been identified in the Federal Prison System?

   There have been 95 identified AIDS cases.

3. What is the primary means of transmission of AIDS cases among those entering the prison system -- IV drug user, homosexuality?

   The primary means of transmission is IV drug use.

4. How many Federal prison inmates have tested seropositive for the HIV virus?

   A total of 295 have tested seropositive for the HIV antibody since 1981.

5. When a prisoner is diagnosed as having AIDS, what course of action does the Bureau take? Is he/she segregated within a facility or sent to a prison hospital?

   Male inmates who are diagnosed as having AIDS are transferred to the Medical Center for Federal Prisoners, Springfield, Missouri, for evaluation and treatment. Female inmates who are diagnosed as having AIDS are transferred to the Federal Correctional Institution, Lexington, Kentucky.

6. What action does the Federal Bureau of Prisons take if an incoming prisoner is seropositive for the HIV virus, but does not have AIDS? Who is informed of the prisoner's condition?

   Inmates testing positive for the HIV antibody are counselled by the Chief of Health Programs at their institution concerning risk behavior and how to avoid such behavior. These inmates are mainstreamed in the general population. The inmate is aware of his HIV status, as is the medical staff.

7. Are prisoners with ARC segregated in a separate facility?

   Inmates with ARC are mainstreamed in the general inmate population.

8. Is the Bureau considering plans to segregate HIV infected prisoners in a separate facility?

   The Bureau of Prisons is not planning any segregation of HIV infected inmates based solely on their HIV status.

9. Under what circumstances is a Federal prisoner sent to the U.S. Medical Center for Federal Prisoners in Springfield, Missouri?

   Inmates are transferred to the Medical Center for Federal Prisoners, Springfield, Missouri, for medical conditions that require hospitalization and specialized treatment.

10. If a prisoner is found to be HIV infected, when tested 60 days prior to release, what action does the Bureau take?

    a) Is he/she released?

       The inmate is released.

    b) Is the Probation/Parole Officer notified of the AIDS infection?

       The Chief Probation/Parole Officer is informed of the inmate's HIV status.

    c) Does the Bureau notify the State health authorities in the State in which the individual will be residing?

       The Bureau does not notify the State authorities.

d) Does the Bureau notify the spouse?

The Bureau does not notify the spouse.

11. What is the incidence of AIDS/HIV infection among female prisoners?

Since 1981 eight female inmates have been diagnosed as having AIDS. Sixty female inmates have tested HIV antibody positive since 1981.

12. Have any of the babies born to prisoners been found to have contracted AIDS?

There have been two babies born to female inmates that have been found to be HIV antibody positive.

13. Is there any evidence that prisoners are contracting the HIV virus while incarcerated?

There is no evidence to suggest that inmates are contracting the HIV while incarcerated in Federal prisons.

14. Is the Bureau undertaking any additional measures to inhibit already prohibited prison behavior, e.g., homosexuality or IV drug use, through which the AIDS virus is transmitted?

Inmates who are HIV antibody positive and refuse to stop behavior that poses a danger to other inmates and staff are segregated. Please refer to the enclosed copy of the Program Statement on "procedures for handling of HIV positive inmates who pose danger to others."

15. Does the Federal Bureau of Prisons pay for the medical care and treatment of prisoners with AIDS and ARC out of its budget? Or, are inmates eligible for medicaid?

The Bureau of Prisons incurs the cost for the care and treatment of those inmates diagnosed as having AIDS. Federal inmates are not eligible for medicaid.

16. Are conjugal visits allowed in the Federal Prison System? If so, are conjugal visits allowed inmates found to be HIV infected?

Conjugal visits are not allowed in the Federal Prison System.

17. Does the Bureau conduct AIDS prevention education for inmates?

    The Bureau of Prisons does conduct AIDS prevention education for all newly incarcerated inmates. Inmates who are HIV positive are counselled by the Chief of Health Programs at their institution concerning risky behavior and how to avoid such behavior.

18. Does the Bureau conduct AIDS prevention education for Correctional Officers?

    The Bureau of Prisons conducts AIDS prevention education on an annual basis for Correctional Officers. Updated information on AIDS as it becomes available is disseminated to the institution staff.

19. If a prisoner contracts AIDS in prison, and can prove he/she did, can the Bureau be held responsible?

    Inmates are responsible for their risky behavior in prison as they would be if they were not incarcerated. If an inmate would claim HIV infection as a result of any action while incarcerated, this would be a matter that would be determined by the courts.

If we can be of any further assistance, please feel free to contact us.

Sincerely,

J. Michael Quinlan
Director

U.S. Department of Justice
Federal Bureau of Prisons

Program Statement

OPI : General Counsel
Number : 5214.3
Date : October 2, 1987
Subject : PROCEDURES FOR HANDLING OF HIV POSITIVE INMATES WHO POSE DANGER TO OTHERS

EFFECTIVE DATE: October 9, 1987

1. **[PURPOSE AND SCOPE §541.60. In an effort to maintain a safe and orderly environment within its institutions, the Bureau of Prisons may place in controlled housing status an inmate who tests HIV positive when there is reliable evidence that the inmate may engage in conduct posing a health risk to another person.]**

2. DIRECTIVES AFFECTED:

a. Directives Referenced.

O.M. 10-87 (6100), Human Immunodeficiency Virus (HIV).
O.M. 73-87 (6100), Human Immunodeficiency Virus Admission and Pre-Release Program.
P.S. 5030.2, Holdovers in Federal Institutions.

b. Rules cited in this Program Statement are contained in 28 CFR §541.60-68.

3. BACKGROUND: The Bureau of Prisons has two Operations Memorandums currently in effect (see above) concerning the Human Immunodeficiency Virus (HIV). This Program Statement is specifically concerned with inmates who test HIV positive and who, based on reliable evidence, provide indication they are going to engage in, or continue to engage in, conduct that poses a specific health risk to another person.

The HIV is not easily transmitted. It is not spread through casual contact, such as contact in family settings, prisons, schools, or other groups living or working together. Nor is it spread through the use of drinking cups, eating utensils, or toilet seats. In fact, the available evidence indicates that the virus is transmitted primarily through two very specific routes: blood-to-blood contact (e.g., shared needles) and sexual fluids to blood contact (sexual practices involving passage of fluids).

The Bureau of Prisons has developed an education program to help control the risk and spread of the HIV virus among persons who are confined. A person who tests HIV positive is given counseling about the risks of his behavior. When, despite such education and counseling, a person engages or shows a disposition to engage in high-risk behavior, the Bureau believes it is necessary to immediately implement procedures for removing this person from the general inmate population.

This Program Statement establishes the procedures to follow when an inmate who tests HIV positive indicates by his actions or verbally a disposition to engage in conduct which poses a significant threat to transmit the virus to another person.

[Bold Type - Rules]
Regular Type - Implementing Information

Specifically, individuals who pose such a concern are to be considered for placement in a controlled housing status. If selected for this placement, the inmate is to be afforded, to the extent practicable, those privileges afforded to the general population, except that the opportunity to socialize with others will be limited and closely supervised. The inmate's status will be reviewed regularly, with release to a general population occurring once the perceived danger is alleviated.

4. [STANDARD FOR PLACEMENT IN CONTROLLED HOUSING STATUS §541.61. An inmate may be placed in a controlled housing status when there is reliable evidence causing staff to believe that the inmate may engage in conduct posing a health risk to others. This evidence may be the inmate's behavior, or statements of the inmate, or other reliable evidence.

5. REFERRAL FOR PLACEMENT §541.62.

a. The Warden shall consider an inmate for controlled housing status when the inmate has been confirmed as testing HIV positive and when there is reliable evidence indicating that the inmate may engage in conduct posing a health risk to others. This evidence may come from the statements of the individual, repeated misconduct (including disciplinary actions), or other behavior suggesting that the inmate may engage in predatory or promiscuous sexual behavior, assaultive behavior where body fluids may be transmitted to another, or the sharing of needles.

b. The Warden shall submit a recommendation for referral of an inmate for placement in a controlled housing status to the Regional Director in the region where the inmate is located.]

The written request is to include the basis for the referral, and is to be accompanied by a current progress report, a comprehensive medical report (including a confirmation that the inmate tests HIV positive), and a copy of an up-to-date psychological or psychiatric report.

[c. Based on the perceived health risk to others posed by the inmate's threatened or actual actions, the Warden may, with the telephonic approval of the Regional Director, temporarily (not to exceed 20 work days) place an inmate in a special housing status (e.g., administrative detention, or a secure hospital room), pending the inmate's appearance before the Hearing Administrator. Reasons for this placement, and the approval of the Regional Director, shall be documented in the inmate central file. The inmate should be seen daily by case management and medical staff while in this temporary status, and a psychological or psychiatric assessment report should be prepared during this temporary placement period.]

Where the referral is prompted by an Incident Report received by the inmate, the policy set forth in the inmate discipline program statement with respect to placement in administrative detention is to be followed, while the referral and decision are made concerning a controlled housing status placement. Under that policy, an inmate found to have committed a prohibited act and placed in disciplinary segregation may be placed in post-disciplinary detention for a period ordinarily not to exceed 90 days.

6. [HEARING PROCEDURE §541.63.

a. The Regional Director in the region where the inmate is located shall review the institution's recommendation for referral of an inmate for controlled housing status. If the Regional Director concurs with the recommendation, the Regional Director shall designate a person in the Regional Office or a person at department head level or above in the institution to conduct a hearing on the appropriateness of an inmate's placement in controlled housing status. This Hearing Administrator shall have correctional experience, no former personal involvement in the instant situation, and a knowledge of the type of behavior that poses a health risk to others, and of the options available for dealing with an inmate who poses such a health risk to others.

b. The Hearing Administrator shall provide a hearing to an inmate recommended for controlled housing status. The hearing ordinarily shall take place at the institution housing the inmate.

c. The hearing shall proceed as follows.

(1) Staff shall provide an inmate with an advance written notice of the hearing and a copy of this rule at least 24 hours prior to the hearing. The notice will advise the inmate of the specific act(s) or other evidence which forms the basis for a recommendation that the inmate be placed in a controlled housing status, unless such evidence would likely endanger staff or others. If an inmate is illiterate, staff shall explain the notice and this rule to the inmate and document that this explanation has occurred.]

The "Notice of Controlled Housing Status Hearing" (Attachment A) is prepared by the Hearing Administrator, who sends the "Notice" and a copy of this Program Statement or current rule to the institution for staff delivery to the inmate. The date and time the inmate receives this material are to be recorded on the staff copy of the notice.

[(2) The Hearing Administrator shall upon request of the inmate provide an inmate the service of a full-time staff member to represent the inmate. The Hearing Administrator shall document in the record of the hearing an inmate's request for, or refusal of staff representation. The inmate may select a staff representative from the local institution. If the selected staff member declines for good reason or is unavailable, the inmate has the option of selecting another representative or, in the case of an absent staff member, of waiting a reasonable period (determined by the Hearing Administrator) for the staff member's return, or of proceeding without a staff representative. When an inmate is illiterate, the Warden shall provide a staff representative. The staff representative shall be available to assist the inmate and, if the inmate desires, shall contact witnesses and present favorable evidence at the hearing. The Hearing Administrator shall afford the staff representative adequate time to speak with the inmate and to interview available witnesses.

(3) The inmate has the right to be present throughout the hearing, except where institutional security or good order is jeopardized. The Hearing Administrator may conduct a hearing in the absence of the inmate when the inmate

refuses to appear. The Hearing Administrator shall document an inmate's refusal to appear, or other reason for non-appearance, in the record of the hearing.]

An inmate who refuses to appear at the hearing may still elect to have a staff representative and witness(es) appear in the inmate's behalf.

[(4) The inmate is entitled to present documentary evidence and to have witnesses appear, provided that calling witnesses would not jeopardize or threaten institutional security or individual safety, and further provided that the witnesses are available at the institution where the hearing is being conducted.

(a) The evidence to be presented must be material and relevant to the issue as to whether the inmate can and would pose a health risk to others, if allowed to remain in general prison population. This evidence may come from the statements of the individual, repeated misconduct (including disciplinary actions), or other behavior suggesting that the inmate may engage in predatory or promiscuous sexual behavior, assaultive behavior where body fluids may be transmitted to others, or the sharing of needles.

(b) Repetitive witnesses need not be called. Staff who recommend placement in a controlled housing status are not required to appear, provided their recommendation is fully explained in the record.]

A staff witness who the Hearing Administrator determines can present material and relevant evidence or testimony may not decline to appear.

[(c) When a witness is not available within the institution, or not permitted to appear, the inmate may submit a written statement by that witness. The Hearing Administrator shall, upon the inmate's request, postpone any decision following the hearing for a reasonable time to permit the obtaining and forwarding of written statements.

(d) The Hearing Administrator shall document in the record of the hearing the reasons for declining to hear a witness or to receive documentary evidence.

7. DECISION OF THE HEARING ADMINISTRATOR §541.64.

a. At the conclusion of the hearing and following review of all material related to the recommendation for placement of an inmate in a controlled housing status, the Hearing Administrator shall prepare a written decision as to whether this placement is warranted. The Hearing Administrator shall:

(1) Prepare a summary of the hearing and of all information presented upon which the decision is based; and

(2) Indicate the specific reasons for the decision, to include a description of the act, or series of acts, or other reliable evidence on which the decision is based, along with evidence of the inmate's HIV positive status.]

This description must be sufficiently detailed to give a reader the information upon which the decision is based.

[b. The Hearing Administrator shall advise the inmate in writing of the decision. The inmate shall receive the information described in paragraph a. of this section unless it is determined that the release of this information could pose a threat to individual safety, or institutional security, in which case that limited information may be withheld. The Hearing Administrator shall advise the inmate that the decision will be submitted for review of the Regional Director in the region where the inmate is located. The Hearing Administrator shall advise the inmate that, if the inmate so desires, the inmate may submit an appeal of the Hearing Administrator's decision to the Regional Director. This appeal, with supporting documentation and reasons, must be filed within five working days of the inmate's receipt of the Hearing Administrator's decision.]

The date and time the inmate receives the written decision (Attachment 8) of the Hearing Administrator, and the name and signature of the staff member notifying the inmate, shall be recorded on the notification and on the central file copy of the notification.

[c. The Hearing Administrator may order the continuation of the inmate in special housing pending review by the Regional Director. The Hearing Administrator should state the reasons for this order in the record of the Hearing.

d. The Hearing Administrator shall send the decision, whether for or against placement in a controlled housing status, and supporting documentation to the Regional Director. Ordinarily, this is done within 20 working days after conclusion of the hearing. Any reason for extension is to be documented.

8. REGIONAL DIRECTOR REVIEW AND APPEAL §541.65.

a. The Regional Director shall review the decision and supporting documentation of the Hearing Administrator and, if submitted, the information contained in an inmate's appeal. The Regional Director shall accept or reject the Hearing Administrator's decision within 30 working days of its receipt, unless for good cause there is reason for delay, which shall be documented in the record. The authority of the Regional Director may not be delegated below the level of acting Regional Director.

b. The Regional Director shall provide a copy of his decision to the Warden at the institution housing the inmate, to the inmate, and to the Hearing Administrator.]

The Regional Director will send the inmate's copy in care of the Warden, who is to ensure the copy is delivered to the inmate. The date and time the inmate receives the written decision, and the name and signature of the staff member notifying the inmate, shall be recorded on the notification and on the central file copy of the notification.

If an inmate is approved for controlled housing status, the Warden may then place the inmate in a controlled housing status. This may consist of placement in

Administrative Detention, under close supervision, in a secure hospital room, or in an equivalent setting. If the inmate is to be transferred to another facility, the inmate may be placed in administrative detention, and will be considered in holdover status (see P.S. 5030.2, Holdovers in Federal Institutions). An inmate placed in controlled housing under this policy shall be assigned to a single cell. If single-cell space is not available, the Warden may place an inmate in a cell with another inmate committed under this procedure.

[c. An inmate may appeal a decision of the Regional Director, through the Administrative Remedy Procedure, directly to the Office of General Counsel, Bureau of Prisons, within 30 calendar days of the inmate's receipt of the Regional Director's decision.]

The inmate will be advised of the right to appeal in the notification sent the inmate by the Regional Director (see paragraph b. above).

9. **[PROGRAMS AND SERVICES §541.66. To the extent consistent with available resources and the security needs of the institution, an inmate in controlled housing status is to be considered for activities and privileges afforded to the general population. This includes, but is not limited to, providing an inmate with the opportunity for participation in an education program, library services, counseling, and religious guidance, as well as access to case management, medical and mental health assistance, and legal services, including access to the institution's law libraries. An inmate in controlled housing status should be afforded at least five hours weekly recreation and exercise out of the cell. The recreation shall be by himself or under close supervision. Unless there are compelling reasons to the contrary, institutions shall provide commissary privileges and reasonable amounts of personal property. The Warden may restrict for reasons of security, fire safety, or housekeeping the amount of personal property that an inmate may retain while in controlled housing status. An inmate shall be permitted to have a radio, provided it is equipped with ear plugs. Visits shall be carefully monitored.]**

The general policy in this area is that an inmate in controlled housing status is to be provided, to the extent practicable, the same privileges as inmates in the general population. Because of the health threat posed by the individual's behavior or threatened behavior, the inmate's involvement in these areas and the opportunity to socialize may be more limited than that provided to the general population. For example, an inmate in a controlled housing status may be enrolled in correspondence courses rather than attend the academic school. This also means that the inmate's recreation time must be under close supervision to help protect the health and safety of others.

Any limitation on food services and personal hygiene care must, at a minimum, be no greater than those specified for inmates in special housing status. Disposable utensils or other special articles may be appropriate for those who are assaultive. Legal, visiting, correspondence and telephone privileges are to be provided in accordance with the existing Bureau policy in these areas.

10. RECORDS. Detailed records are to be maintained. All admissions to controlled housing status will be recorded indicating date, time, the specific reason for admission and the authorizing official on BP Form 292. All releases, of any type,

from this status will be similarly recorded. Staff shall maintain records regarding meals, showers, recreation, medication, medical and mental health visits and treatment. Staff shall record unusual activity or behavior of the inmate. This will include both positive and negative behavior, the records of which become a part of the inmate's central file. Officials visiting the inmate in controlled housing status will sign a log, giving time, date, and reason for visit.

11. [REVIEW OF CONTROLLED HOUSING STATUS §541.67.

a. Staff designated by the Warden shall evaluate regularly an inmate's adjustment while in controlled housing status. A medical staff member shall see the inmate daily, and regularly record medical and behavorial impressions. Once every 90 days, staff, comprised of a correctional and case management supervisor, and a member of the medical staff, shall meet with the inmate. The inmate is required to attend this meeting in order to be considered for release to the general population. Any refusal by the inmate to attend this meeting will be documented.

Staff, at this meeting, shall make an assessment of the inmate's adjustment while in controlled housing and the likely health threat the inmate poses to others by his actions.]

Staff, at this review, are to have available the collected data of daily activity and a psychiatric or psychological assessment report, and they will conduct a personal interview. The psychiatric or psychological assessment shall address the inmate's adjustment to surroundings and the threat the inmate poses to self, staff, and other inmates if released. Staff shall conduct similar psychiatric or psychological assessments and prepare a written report at no less than 90-day intervals for the duration of the inmate's stay in controlled housing status. This staff shall make any recommendations as to release from controlled housing status.

[b. The Warden shall serve as the review authority at the institutional level, and shall make a recommendation to the Regional Director when he believes the inmate should be considered for release from controlled housing.

c. An inmate may appeal a Warden's decision not to recommend release from controlled housing to the Regional Director within five working days of receipt of that decision.

d. Upon recommendation of the Warden, or upon appeal from the inmate, the Regional Director may decide whether or not to release the inmate to general population from controlled housing status.

e. An inmate may appeal a decision of the Regional Director, through the Administrative Remedy Procedure, directly to the Office of General Counsel, Bureau of Prisons within 30 calendar days from the date of the Regional Director's decision.

12. [RELEASE FROM CONTROLLED HOUSING STATUS §541.68.

a. Only the Regional Director may release an inmate from controlled housing status. The following factors are considered in the evaluation of an inmate's readiness for return to the general population:]

[(1) Relationships with other inmates and staff members, which demonstrate that the inmate is able to function in a less restrictive environment without posing a health threat to others or to the orderly operation of the institution;

(2) Involvement in work and recreational activities and assignments or other programs; and

(3) Adherence to institution guidelines and Bureau of Prisons rules and policy.

b. An inmate released from a controlled housing status may be returned to the general population of that institution, or to another federal or non-federal institution.]

J. MICHAEL QUINLAN
Director

ATTACHMENT A 5214.3 10/2/87

NOTICE OF CONTROLLED HOUSING STATUS HEARING - Page 1 of 3

The original of this Notice was delivered to the inmate (date/time) _____
by (staff member's signature/printed name) _____

DATE:

To: Inmate's Name - _____ Register Number: _____

Institution - _____

From: Hearing Administrator - _____

You have been referred for a hearing before a Controlled Housing Status Hearing Administrator. This hearing is to determine if you should be confined in a controlled housing status. Information concerning this referral, the hearing, and your rights at this hearing are set forth in this Notice.

1. Scheduled Date and Location for Hearing: _____

2. Brief summary of the act(s) resulting in the recommendation for this placement:

3. You are entitled to have a full-time staff member represent you at this hearing. Please indicate whether you desire to have a staff representative and, if so, the person's name.

☐ I wish to have the following staff representative: _____

☐ I do not want a staff representative.

4. You have the right to call available witnesses at the hearing and to present documentary evidence. It is not the purpose of this hearing, however, to "re-hear" any prior disciplinary proceedings. The testimony of witnesses and the documentary evidence presented must be relevant to the issue of whether you can and would function in a general prison population without your actions posing a threat to others. Witnesses providing repetitive testimony, witnesses not available at the institution, and witnesses whose appearance at the hearing would jeopardize institutional safety, will not be called. You may, however, submit such testimony in the form of a written and signed statement(s).

Please indicate on the next page if you wish to call available witnesses. If you do wish to call witnesses, give their names, along with a brief description of their expected testimony.

ATTACHMENT A 5214.3 10/2/87

NOTICE OF CONTROLLED HOUSING STATUS HEARING - Page 2 of 3

INMATE'S NAME: REGISTER #: DATE:

5. a. ☐ Initial this box if you do not want to call any witnesses.

b. If you do want to call available witnesses, give their names and a brief description of their expected testimony.

Name: _____ Can testify to: _____

Name: _____ Can testify to: _____

Name: _____ Can testify to: _____

Name: _____ Can testify to: _____

c. List the names of those witnesses from whom you intend to obtain written statements.

Name: _____ Can make a statement to: _____

Name: _____ Can make a statement to: _____

Name: _____ Can make a statement to: _____

Name: _____ Can make a statement to: _____

If additional space is needed, use the reverse side of this form. Failure to complete the form will be considered as your waiver to witnesses and staff representation.

Signature of Inmate: _____ Date: _____

ATTACHMENT A 5214.3 10/2/87

NOTICE OF CONTROLLED HOUSING STATUS HEARING - Page 3 of 3

INMATE'S NAME: REGISTER #: DATE:

6. Inmate Rights at Hearing - As an inmate referred for placement in a controlled housing status, you have the following rights:

   a. The right to have a written summary of the specific act(s) or other evidence which forms the basis for this recommendation, unless such information would likely endanger staff or others. You have the right to receive this summary at least 24 hours prior to the hearing.

   b. The right to have a full-time member of the staff who is reasonably available to represent you before the Hearing Administrator.

   c. The right to be present throughout the hearing except where institutional security or good order would be jeopardized. If you elect not to appear before the Hearing Administrator, you may still elect to have a staff representative and witnesses appear in your behalf.

   d. The right to call available witnesses and to present documentary evidence in your behalf which is relevant to the issue, provided institutional security or individual safety would not be jeopardized.

   e. The right to be advised, in writing, of the Hearing Administrator's decision and of a summary of the facts and reasons supporting this decision, to the extent institutional security or individual safety would not be jeopardized.

   f. The right to appeal the recommendation of the Hearing Administrator by a written appeal to:

      Regional Director
      Bureau of Prisons

      _____

      _____

   This appeal, with supporting documentation and reasons, must be filed within five work days of the inmate's receipt of the Hearing Administrator's decision.

---

7. I have been advised of the above rights afforded me at a Controlled Housing Status hearing. I have also received a copy of the current Program Statement or rule on controlled housing status.

Signature of Inmate: _____ Date: _____

---

8. When an inmate has been advised of the above rights and provided a copy of the current Program Statement or rule on controlled housing status, but refuses to sign the acknowledgement, the following is to be completed:

   I have personally advised _____ of the above rights, and provided the inmate a copy of the current Program Statement or rule on controlled housing status; however, the inmate refused to sign the acknowledgement.

Signature of Employee: _____ Date: _____

Printed Name of Employee:

ATTACHMENT B 5214.3 10/2/87

CONTROLLED HOUSING STATUS HEARING ADMINISTRATOR'S REPORT - Page 1 of 2

INMATE'S NAME: REGISTER #: DATE:

1. Notice of Hearing:

   a. The "Notice of Controlled Housing Status Hearing" was given to the above named inmate on (date) _____ at (time) _____. A copy of this Notice is attached.

   b. The hearing was held by (Hearing Administrator) _____, from (location) _____, on (date) _____ at _____. The inmate was __ present; ____ not present for the following reason(s): _____. A summary of the inmate's statement is attached.

---

2. Staff Representation: The inmate was advised, in the "Notice of Controlled Housing Status Hearing", of the right to select a staff representative.

   a. ____ The inmate elected to proceed without a staff representative.

   b. ____ The inmate selected a staff representative, who appeared at the hearing. The staff representative selected was _____. A summary of the representative's statement given at the hearing is attached.

---

3. Appearance of Witnesses: The inmate was advised, in the "Notice of Controlled Housing Status Hearing", of the right to have witnesses appear at the hearing.

   a. ____ The inmate elected to proceed without the benefit of witnesses.

   b. ____ The inmate selected the following witnesses to appear.

   Reason requested witnesses were not called:

   A summary of witness(es) statements given at the hearing is attached.

---

4. Presentation of Documented Statements: The inmate was advised, in the "Notice of Controlled Housing Status Hearing", of the right to submit documentary evidence.

   a. ____ The inmate declined to present any documentary evidence to the Hearing Administrator.

   b. ____ The inmate presented the following documentary evidence.

   A copy of the documentary evidence is attached.

---

5. Inmate's Physical and Mental Health:

_____
Signature of Medical Staff Member

ATTACHMENT B 5214.3 10/2/87

CONTROLLED HOUSING STATUS HEARING ADMINISTRATOR'S REPORT - Page 2 of 2

INMATE'S NAME: REGISTER #: DATE:

6. Finding:

7. Decision:

8. Inmate to be continued in special housing pending Regional Director review?
___ No; ___ Yes (If yes, state reasons)

9. Appeal Rights: You have the right to appeal this decision by forwarding a written appeal to:

Regional Director
Bureau of Prisons
_____
_____

Your appeal must be filed within five (5) work days following receipt of the Hearing Administrator's decision. The final decision is made by the Regional Director.

Signature of Hearing Administrator: _____ Date: _____

Printed Name of Hearing Administrator: _____

10. I hereby acknowledge that I have received a copy of the Hearing Administrator's decision on (date) _____ at (time) _____.

Signature of Inmate: _____

Signature/Printed Name of Employee: _____

11. When an inmate refuses to sign for a copy of the decision, the following is completed.

I have personally delivered a copy of the Hearing Administrator's decision to the above-named inmate; however, the inmate refused to sign the acknowledgement.

Date/Time of Delivery: _____

Signature/Printed Name of Employee: _____